

Lesson Plan 1: History of the Mental Health System

I. Course Goals:

Illustrate how people's experiences with and knowledge of earlier mental health systems and treatment can influence their beliefs and behaviors.

II. Performance Objectives:

Upon completion of this class the student will be able to:

1. Describe the historical treatment of the mentally ill and developmentally disabled.
2. Recount the conditions in institutions and society that contributed to the movement to de-institutionalize people with mental illness.
3. Compare the goals of de-institutionalization with the reality of its implementation (including the jail as the new version of the institution).
4. Recognize the effects of the first medications used to treat mental illness.

III. Methodology

Class will be taught in lecture format with the use of video to illustrate teaching points.

IV. Materials, references, and equipment

1. Projector and screen
2. DVD player
3. Flip charts
4. Colored pens
5. DVD "Snake Pit."

V. Content

See below

HISTORY OF THE MENTAL HEALTH SYSTEM

1. 18th century America held beliefs leftover from our European predecessors: the mentally ill were "possessed," to be feared
2. The early 19th century brought an era of "moral treatment," establishing state mental asylums
3. By mid century, changes were occurring in the mental health system: the hospital census had grown and institutional care began to deteriorate and the care of the mentally ill became known as "warehousing"
4. 1949: the National Institute of Mental Health was established
5. Media exposure increased public awareness of deplorable hospital conditions
6. 1950's: discovery of the first major tranquilizers, thorazine being one of the first
7. 1950's and 60's: the national conscience focused on the civil rights movement
8. As social reform responded to deplorable hospital conditions, the movement toward deinstitutionalization began
9. Transfer of hospital patients to the community-based care began and culminated in the Community Mental Health Act of 1963.
10. Ideally clients discharged from institutions would live within family support systems
11. In reality, persons had been "institutionalized": withdrawn, dependent, minimal social skills, years of estrangement from their families/supports; many discharged to nursing homes, single room occupant/low income housing units, and hotels
12. By the end of the 70's, the mentally ill were among the ranks of the homeless
13. The 80's and 90's brought cuts in low income housing, reduction in disability entitlements including the mentally ill, changes in insurance coverage, and a decreased tolerance for persons on the social margins
14. Significant changes in mental health coverage, lack of parity, insufficient reimbursement rates for community providers resulted in an overload of the mental health system
15. The mentally ill became casualties of a well-intended change; unfortunately the criminal justice system and homeless shelters are now frequently the "community partners" in caring for the mentally ill
16. Oregon/Multnomah changes: payor system has changed numerous times over the years; causing service providers to adapt their systems

17. Client's mental health coverage has been cut; they have experienced times when Oregon Health Plan was not taking new patients, or only medical coverage was provided and not mental health
18. Only this January (2007) has Oregon established parity for mental health, finally equalizing insurance coverage for mental illness with medical care

Lesson Plan 2: Current Mental Health System and Services

I. Course Goals:

Identify elements of today's mental health system in Multnomah County.
Understand and appreciate the limitations, stresses and strains on the system
and how these limitations affect the officer's day to day work.

II. Performance Objectives:

1. Communicate effectively with other professionals by understanding their roles and functions
2. Know how to access "gateway" resources such as Project Respond, Hooper, and the Multnomah County Crisis Line
3. Describe programs within Project Respond
4. Articulate how stigma is a barrier to treatment of individuals with mental illness/developmental disabilities

III. Methodology

Class will be taught in lecture format with brainstorming and discussion sessions.
Consumer videos are used throughout the training to highlight the issue of stigma
and its effect on individuals suffering from mental illnesses.

IV. Materials, reference and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint capability
4. Consumer video(s)

V. Content

See following page

COMMUNICATING WITH THE MENTAL HEALTH SYSTEM:

- 1) **CASE MANAGER:**
 - a) A person usually working with a clinic who provides assistance with connecting to resources for housing, food stamps, job training, personal care, housekeeping assistance, legal issues, social security entitlements, group supports
 - b) They do initial and ongoing mental health assessments
 - c) They connect clients with a licensed medical provider (LMP)
 - d) They provide therapy/counseling
 - e) They frequently have caseloads of more than 100 clients
- 2) **COUNSELOR/THERAPIST:** Some clients may refer to their case manager as a counselor.
- 3) **MONEY MANAGER/PAYEE:** Clients who receive Social Security may be required to have a representative payee who assists the client in paying for rent, groceries, bills, back debt, etc. They generally see their money manager anywhere from once a week to once a month. Clients can also have money management services on a voluntarily basis.
- 4) **LICENSED MEDICAL PROVIDER (LMP):** This can be a nurse practitioner, physician assistant, psychiatrist, or a primary care physician; generally clients see their LMP (also called a "prescriber") once or twice a month to once every three months depending on their stability and ability to track appointments.
- 5) **VERITY/VERITY PLUS:** This refers to the mental health coverage within the Oregon Health Plan for Multnomah county; a client may say they "have lost their Verity"; this means their medications or clinic visits are not covered. Their case manager can help with reapplication for Verity, but the coverage will be for a limited period of time.
- 6) **CRISIS LINE:** A Multnomah County 24 hour crisis line (503-988-4888) available to citizens, consumers/clients, hospitals, police, dispatch.
- 7) **CORE/INTENSIVE CASE MANAGEMENT:** A specialty case management service with much smaller caseloads; they respond on scene to crises (sometimes with Project Respond).
- 8) **OUTREACH PROGRAMS:** Project Respond (mentally ill homeless), JOIN (homeless camps), Central City Concern, New Avenues for Youth and Yellow Brick Road (youth focus), NARA (Native American focus).
- 9) **SRO:** single room occupancy; many of the hotels downtown, some subsidized.
- 10) **HIPAA:** A national policy setting standards for security and privacy of health data, standards for electronic data, and protections for health insurance for workers who change or lose their jobs.

- 11) Personal care assistant: One paid to assist with housekeeping, hygiene, shopping, activities of daily living.
- 12) PSRB: Psychiatric Security Review Board (see lesson plan # 17)
- 13) CEP: Community Engagement Program-provides services including housing, case management, psychiatric and medical care, to homeless persons with co-occurring disorders in Multnomah Co.
- 14) Co-occurring disorders: When a person is experiences two or more ongoing illnesses; could be a mental illness along with substance abuse, or a developmental disorder with substance abuse.
- 15) Urgent Walk-In Clinic: A service through Cascadia Behavioral Health for individuals seeking urgent mental health services;
 - a) Clients are provided with a risk assessment, crisis counseling and recommendations for further treatment.
 - b) Primary focus is those who are indigent, OHP eligible or Medicare only and not enrolled in MH services.
 - c) Sometimes short term medications are provided.
 - d) they are open 7 days/week 7am to 10:30pm.
 - e) Clinic is ONLY FOR VOLUNTARY CLIENTS.
 - f) If officers are taking client to clinic, they would need to accompany client into clinic waiting room, ask for program manager or clinician, then inform them how their contact with client originated.
 - g) Officers are welcomed to call ahead to let clinic know they are coming, or problem solve re: appropriate response; officers can also call Project Respond for consultation or assistance with evaluation.
 - h) If a client says he/she is currently seen at another Cascadia clinic, it would be preferable for client to go to their primary clinic if Monday -Friday, 8am-5pm.
- 16) Community Court: for low-level offenders, non-person to person crimes, misdemeanors and violations only:
 - a) Goal is to get them services so they don't re-offend
 - b) Could include mental health, drug and alcohol services, economic or educational services
 - c) It is voluntary; upon entering the program, client signs agreement for automatic jail sentence if they fail
 - d) If officers have questions re: program, contact is Heidi Grant: 988-5090 x24508
- 17) Medication Scholarship/Patient Assistance Program: Some pharmaceutical companies provide 3-6 month supply of medications to clients who qualify; their prescriber and case manager assist with this process.

Lesson Plan 3: Mental Status Exam

I. Course Goals:

Recognize that mental illness is a brain disorder and comprehend terminology used to describe the signs and symptoms of mental illnesses. Show how imperfections in brain functioning affects people's behavior.

II. Performance Objectives:

Upon completion of this class the student will be able to:

1. Familiarize students with a Mental Status Exam
2. Assess a person's appearance
3. Describe a person's thought process and thought content
4. Describe a person's speech pattern
5. Practice articulation of mental status indicators for report writing purposes

III. Methodology:

Class will be taught in lecture format with the use of PowerPoint, demonstration, video and one activity/game. Videos and activity will be interspersed with lecture material to illustrate different examples of thought processes, speech patterns, movements, insight and judgment.

IV. Materials, references and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint
4. Index cards for activity
5. "Cops" videos: "Woman in Shower" and "Street Party"

V. Description of "matching game" Activity:

The activity consists of a matching game where each student receives a card. Written on one set of cards in red ink are statements describing specific mental status indicators. Written on another set of cards in black ink are the clinical names for the mental states.

Example: -"I am the Queen of Wales" paired with "Grandiose Delusion."

VI. Content :

See following page

OVERVIEW OF MENTAL ILLNESS AS A BRAIN DISORDER

1. Not all brain disorders are mental illnesses, but all mental illnesses are brain disorders.
2. The brain regulates our thoughts, feelings, behaviors, and communication.
3. It provides us with a way of testing reality, solving problems.
4. Mental illness can affect all areas of the brain by changing the actual structure of the brain, the chemistry, and electrical impulses.
5. Mental illness is not mental retardation, a split personality, and does not imply a lower IQ.
6. Causes of brain dysfunction can be numerous and chronic or acute:
 - Anatomical abnormality or damage
 - Lack of oxygen / glucose
 - Electrolyte imbalance
 - Neurotransmitter dysregulation
 - Viral
 - Genetic: specific proteins within genetic markers
 - Autoimmune
 - Developmental
 - Substance abuse
 - Nutritional deficits: e.g. omega3 fatty acids
7. Brain disorders and mental illness can be acute or chronic, e.g. psychosis vs. schizophrenia, depressive disorders
8. Mental illness is frequently a long road of remissions and exacerbations, being in and out of treatment, as well as difficulties negotiating a changing mental health system.

FUNCTIONS WHICH CAN BE AFFECTED BY MENTAL ILLNESS

1. Level of attention: e.g. distractable, alert, hypervigilant, somnulent
2. Orientation: person, time, place, situation

3. Emotional reactions; anxious, agitated, apathetic, fearful
4. Mood: depressed, irritable, labile, euthymic (normal level)
5. Affect: (facial expression) appropriate, restricted, flat, does it fit with mood?
6. Physiological reactions: sleep, appetite, libido
7. Motor activity: may be voluntary or involuntary
 - a. Posturing- abnormal, even bizarre positioning
 - b. Catatonia- may be immobile, or repetitive activity
 - c. Echolalia can occur- senseless repetition of a word or phrase just heard
 - d. Echopraxia- imitation of movements of another person
 - e. Person may need supervision to avoid self harm
 - f. Tic-involuntary spasmodic movement
 - g. Compulsion- uncontrollable impulse to perform a repetitive act, may be ritualistic, often in response to an anxiety-driven obsession
8. Speech qualities
 - a. Rate, rhythm, volume
 - b. Pressured- generally rapid, occasionally loud
 - c. Poverty of speech- restricted amount
 - d. Dysarthria- difficulty articulating due to motor deficit
9. Language- called aphasia
 - a. Expressive/motor
 - b. Receptive- cannot comprehend meaning of words
 - c. Nominal- cannot name objects
 - d. Syntactical- cannot arrange words in logical order
10. Memory-function by which information is stored and able to be brought to consciousness
 - a. Immediate, short term, and long term (distant)
 - b. Amnesia may be organically or emotionally caused

11. Insight- ability of person to understand cause and meaning of a situation
 - a. May refer to their illness, benefit of treatment
12. Judgment- ability to correctly assess a situation and respond appropriately to the situation; indicator of person's ability to provide for own safety
13. Thought- the flow of ideas, symbols, and associations which lead toward a reality oriented conclusion. Disturbances in the FORM of thought which can occur in mental illness:
 - a. Flight of ideas- shifting of ideas in a slightly connected, continuous manner, can be a play on words
 - b. Loosening of association- thoughts shift in an unrelated manner from one idea to another
 - c. Incoherence- unable to understand thoughts due to complete disorganization
 - d. Word salad- incoherent mixture of words
 - e. Neologism-creation of new words
 - f. Circumstantial thinking- delay in reaching 'the point'; over-inclusion of details, superfluous ideas
 - g. Tangential thinking- thoughts frequently change their course away from the original idea, become non goal-directed
 - h. Concrete thinking- literal, limited ability to understand metaphor
 - i. Perseveration- persistent responses even after the topic has been changed, continues to return to the same theme or idea
 - j. Thought blocking- interrupted or disturbed ability to process information resulting in pauses in flow of thought and ability to respond
 - k. Magical thinking- thoughts, words can assume power, many times childlike
14. Thought content/Delusion: beliefs incorrectly inferred from external reality, cannot be corrected by reasoning
 - a. Paranoid- being watched, followed
 - b. Persecutory- mistreated, harassed
 - c. Grandeur- grandiose ideas, special powers

- d. Somatic- body related
 - e. Bizarre- odd mix of delusions
 - f. Ideas of reference- believe behaviors of others refers to the person, may feel talked about, e.g. the TV speaks only to them, special messages
 - g. Ideas of influence- beliefs that another person or force controls some aspect of their behavior
 - h. Thought broadcasting- perceive their thoughts can be heard by others
 - i. Thought insertion- perceive thoughts are being planted into their mind by others
 - j. Obsession- pathological persistence of thought or feeling, is irresistible
15. Perceptual disturbance/Hallucination: false sensory perception not associated with a real external stimuli, causes impairment in reality testing
- a. Auditory- sounds, voices, vary in quality. May be inside or outside one's head, may be commanding/instructional, frequently negative, may cause one to respond verbally
 - b. Visual- formed or distorted images
 - c. Olfactory- frequently foul
 - d. Gustatory- foul, chemical
 - e. Tactile- skin, extremity, e.g. skin crawling, phantom sensation
 - f. Illusion- misinterpretation of real sensory stimuli

Lesson Plan 4: Crisis Communication (Part I)

I. Class goals:

This class provides the foundational concepts for crisis communication. It will familiarize students with the model of the "crisis cycle" and the communication techniques appropriate to various stages of the crisis cycle. The information in this class will be utilized during the entire course in all role plays, scenarios, demonstrations and video reviews.

II. Performance objectives:

Upon completion of this class the student will be able to:

1. Describe the stages of the crisis cycle
2. Identify behaviors that indicate where an individual might be on the crisis cycle
3. Use different communication techniques depending on where an individual is on the crisis cycle
4. Observe signs of escalation and de-escalation in a subject and link these signs to an officer's communication techniques
5. Gain awareness that officers are also on the crisis cycle

III. Methodology

Class will be taught in lecture format (PowerPoint) with brainstorming and discussion sessions interspersed throughout. Class will utilize "COPS" videos to practice skills.

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint
4. "Cops" video: "Backyard Man" (Cops disk 2) & "Woman in Van" (Cops disk 1)

V. Content

Attach power point

Lesson Plan 5: Crisis Communication (Part II)

I. Class goals:

This class will review basic communication theory and apply that theory to crisis interactions.

II. Performance Objectives:

Upon completion of this class students will be able to:

1. Identify 3 basic components of communication:
 - i. Sender
 - ii. Receiver
 - iii. Message
2. Describe various non-verbal methods of communication
3. Understand communication to be an interactive, dynamic and complex process
4. Understand the importance of attending to the emotional content of a message
5. Describe the power of an apology and its application to community policing

III. Methodology

Class will be taught using lecture, videos and discussion

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with power point
4. DVD: "Abbott and Costello", "Jerry Maguire," "Jerry Seinfeld"
5. "Cops" video: "Deaf Woman"

V. Content

(See next page))

COMMUNICATION REVIEW

I. The importance of communication (and CIT)

- a. CIT is about communicating effectively with people in crisis. Not just the mentally ill.
- b. Is there a difference between talking and communicating? If so, what is it?
- c. Communicating well is a learned skill.
- d. CIT is not a magic bullet. It is another tool in your tool belt.
- e. CIT gives some additional understanding of the state of mind that people are in when they are motivated by fear and how we might interact with them in this state.
- f. Fear is a dangerous emotion. The more we can lessen someone's fear, the safer YOU will be.

II. Communication theory review

a. Theory review

- i. Most people think of communication as a line.
- ii. But it quickly becomes complicated. *Ex: Say you are home and about to leave for work. You walk through the kitchen and your spouse says: "The trash is full." You keep walking and say, "Why, yes it is." And walk out of the house.*
 1. What is the person REALLY saying? What message are you hearing? What message do you need to respond to? The words are saying one thing but the context gives it a whole other meaning.
 2. In order to communicate effectively we have to **understand the difference between the words and the meaning**. Paying attention to the words but not the meaning can get you into trouble. **Show video "Abbott and Costello."**
 3. Debrief video. Ask class why the communication broke down. Elicit and write on whiteboard what goes into successful communication (options: listening, clarification, frame of reference, assumptions, reacting vs. thinking, slowing down). What EMOTIONS are operating in this scene?

iii. Three major components to communication

1. (Draw stick figures) Sender-message-receiver. Message is mostly verbal. BUT in addition to an intended verbal message we send lots of unintended messages ALL THE TIME. What are those unintended, non-verbal messages?
 - a. Voice, tone, volume, speed, body language- like facial expressions, eyes- personal history and past experiences, personal space, etc
 - b. **Students guess % that people pay attention to verbal, tone & volume and body language. Draw pie chart with % verbal (7), tone & volume(38) and body language (55).** (Study with these percentages done in 1981 by Albert Mehrabian out of UCLA. He wrote a book called, "Silent Messages: Implicit Communication of Emotions and Attitudes")

iv. Catching the (emotional) message

1. If we don't catch the emotional message, the message gets amplified! What happens when you talk to a deaf person? You talk louder!
 - a. The person escalates until the emotional message is caught. In a relationship, you can have emotional messages that are not caught for years. Leads to divorce.
 - b. **Video:** "Jerry McGuire" clip to illustrate escalation of emotions. Kid says "f... you" because Jerry is not paying attention to him.

v. Power of an apology

1. If the message is not caught and the person feels powerless what will they do? Many things, but one thing is they will sue! Modern day form of revenge, retaliation is suing.
 - a. Study: Wendy Levinson (2002) studied doctor-patient relationships and found that when doctors apologized for their mistakes, # of malpractice claims decreased.
 - b. Study: New York Times article May 18th, 2008 "Doctors say 'I'm sorry' before 'See you in court.'" Same finding as Levinson. Johns Hopkins and Stanford trying new approach of admitting fault vs. "deny and defend."
2. **Movies: Video: Jerry Seinfeld. Customer service example of "revenge."**
3. **Video: Cops (#1) "Deaf Woman."** Video is broken into two parts. Part I: police take a deaf woman into custody. Part II: Officer talks to deaf woman family member. This is the interesting part of the video. Pause the video to ask questions:
 - a. Where is the family member on the crisis cycle?
 - b. Is she listening to the officer? Why not? (think crisis cycle)
 - c. How is the officer talking to her? (problem-solving)
 - d. What is her emotional state? Is he "catching" her emotions?
 - e. What does he do well? (Uses her name, nice tone)
 - f. Is he giving her correct and good information? (yes)
 - g. It is a problem of timing. His good info is wasted on her at this point in the conversation.
 - h. When does she start to de-escalate? What helps her de-escalate?
 - i. What does officer say that *does* catch her emotionally and reflects her feelings back to her?

Lesson Plan 6: Crisis Communication (Part III)

I. Class Goals

This class builds on previous communication classes and will present additional communication theory and remind students of the importance of listening. Basic communication recommendations for people in crisis will be reviewed and practiced.

II. Performance Objectives

Upon completion of this class students will be able to:

1. Utilize active listening skills
2. Recall questions used to assess an individual's level of crisis
3. Recognize that the officer is always communicating, even if they are not talking, and that they can be easily drawn into a subject's crisis cycle
4. Differentiate between "reacting" and "responding" and being able to articulate the value of each type of response

III. Methodology

Class will be taught using a combination of lecture, video analysis and demonstration.

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with power point
4. DVD: "Dog Day Afternoon" film clip
5. Cops: "Man with Stick"

V. Content

(See following page)

- I. Communication is a loop, not a line (PowerPoint slide)
 - 1. There is no beginning or end to communication
 - 2. You are always part of that loop because YOU CANNOT NOT COMMUNICATE
 - 3. People get pulled into these communication loops quickly –this can lead to escalation
 - 4. Easy to get pulled into someone's bad mood (not other way around)
 - 5. Non-verbal messages are always present
 - 6. People react unknowingly and unwittingly to hidden, silent messages

II. React vs. Respond

- 1. Verbal Judo concept developed by George Thompson
- 2. Elicit from class the difference and write on board
- 3. React
 - i. The other person is in control
 - ii. You are on the defensive
 - iii. More instinctive, automatic
 - iv. Emotional
 - v. They are calling the shots. Their game. Their rules.
 - vi. Power struggle (remember the top of the crisis cycle-two year olds love power struggles)
 - vii. You can "over react" but not "over respond" (Project Respond not Project React)
 - viii. Awareness of your reactions. You can't control your reactions if you don't know you are having them.
- 4. Respond
 - i. Emotions less engaged
 - ii. Detached
 - iii. Less likely to be pulled into someone's state
 - iv. Realize it is not personal
 - v. More chances to control the conversation
 - vi. Trying to find mutual communication vs. one up
 - vii. More likely to listen in "respond" mode

III. Listening Skills (PowerPoint)

- 1. Elicit "How do we know someone is listening to us?"
- 2. Opposite of "talking" is "waiting to interrupt"
- 3. Techniques for listening:
 - i. Emotional labeling
 - ii. Paraphrasing
 - iii. Reflecting
 - iv. Effective Pauses
 - v. Minimal encouragers
 - vi. Open-ended questions

IV. Making a Connection- (PowerPoint)

Examples:

- 1. I'm here to help you
- 2. What's going on today?
- 3. Do you feel safe?
- 4. What would help you feel safer?

V. Communication Recommendations

1. Limit input
2. Slow down
3. Reduce distraction
4. Short sentences
5. Simple language
6. Repeat yourself (often)
7. Use people's names to help them focus
8. Use silence

Lesson Plan 7: Schizophrenia and Other Psychotic Illnesses

I. Class Goals

Students will gain increased knowledge about schizophrenia and other psychotic disorders. Exposure to the signs and symptoms of these disorders will enable students to appreciate the challenges of this disease. Students will be exposed to a risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this course the student will be able to:

1. Recognize the symptoms of three types of schizophrenia:
 - i. Paranoid
 - ii. Disorganized
 - iii. Catatonic
2. Articulate the risk factors associated with psychotic disorders
3. Through role play exercises, interview a subject with a psychotic disorder to assess safety to self and others
4. Understand the difference between hallucinations and delusions and the risks associated with each
5. Describe the different conditions that might cause someone to become psychotic
6. Appreciate the need to respond to the behavior and not the diagnosis
7. Practice utilization of outside resources, e.g. Project Respond

III. Methodology

Class will be taught in lecture format with the use of video examples and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "I'm Still Here- Introduction"

V. Content

See following page

SCHIZOPHRENIA & OTHER PSYCHOTIC ILLNESSES

Psychosis is not necessarily schizophrenia, psychotic symptoms can occur in numerous medical and psychiatric illnesses

Schizophrenia can disturb thinking in its content (delusion), perception (hallucination), and processing (disorganization)

Schizophrenia has both positive and negative symptoms:

- Positive: delusion, hallucinations, paranoia,
- Negative: social withdrawal, flat affect, poverty of speech, decreased motivation

Types of schizophrenia/what presentation you might see:

- Paranoid
- Disorganized
- Catatonic

Person may identify themselves as "having schizophrenia" but unlikely to know type

Other psychotic illnesses:

- Delusional disorder
- Substance induced psychosis
- Medical condition causing psychosis: eg cranial tumors

Schizoaffective disorder: has clinical signs of schizophrenia, manic and depressive episodes; may be bipolar or depressive type

Mood disorder with psychotic features: psychosis occurs as complication of depression which is usually of long duration and with poor prognosis

Suicide among schizophrenia patients:

- Tend to commit suicide during the first years of illness
- Up to 10% of schizophrenics in US commit suicide
- Tend to be younger, male, single, socially isolated
- Most have previous attempts

MEDICATIONS FOR PSYCHOSIS/SCHIZOPHRENIA

Medical Risk - NMS (Fever, rigid, sweating - medical emergency get paramedics)

Meds work on neurotransmitters, eg dopamine

Development of antipsychotic meds led to deinstitutionalization (thorazine 'discovered' in 1953)

Antipsychotic meds can be used in other disorders; caution in deciding that a person on antipsychotic meds is schizophrenic

Older meds addressed 'positive' symptoms of schizophrenia, did not address the negative: flat affect/vocal quality, apathy, anhedonia, poor attention

Older meds:

- Thorazine, mellaril, navane, trilafon, haldol
- Had profound acute and chronic side effects: eg. dystonias, tardive dyskinesia, cardiac effects, Parkinsons-like symptoms, anti-cholinergic effects

Newer "atypical" antipsychotics:

- clozapine, risperdal, seroquel, zyprexa, abilify, geodon
- less likely to cause side effects of older medications, but have side effects of their own
- Most cause weight gain, elevation in cholesterol, triglycerides; this can lead to metabolic syndrome, type II diabetes and subsequent diabetic complications

Both older and newer antipsychotics can have a severe adverse reaction called neuroleptic malignant syndrome: life threatening high fever, sweating, high blood pressure, increased heart rate, muscle rigidity. It can occur any time during treatment. Clozapine requires frequent blood draws as it can cause a life-threatening blood problem

Other side effects; headache, sleep disturbances, tremors, dry mouth, constipation, dyspepsia, rise in prolactin levels (breast swelling, menstrual irregularity)

Persons have to weigh the risks versus the benefits and should be informed of these by their prescriber, a difficult process when a person is paranoid or thoughts are disorganized

Medication regime may require more medication to treat side effects leading to anticholinergic side effects, such as blurred vision, constipation, difficulty urinating

Medication effects/side effects/ managing of meds presents a significant challenge for a homeless individual. Review of reasons why a person with mental illness may not want meds.

SIDE EFFECTS AND MEDICATIONS USED TO TREAT SIDE EFFECTS:

Neurological/central nervous system:

- Dystonia: muscle stiffness, cramping; generally affects jaw, neck, but could affect other muscles ***Risk-in severe cases airway can close - medical emergency - get paramedics***
- Dyskinesia: referred to tardive dyskinesia: involuntary movements of tongue, jaw, trunk, or extremities; due to medication
- Akathisia: fidgety movements, swings legs, rocking, pacing to relieve restlessness, inability to sit or stand still ***Risk --untreated condition can be intolerable and can result in suicide/attempts***

- Pseudoparkinsonism: tremors caused of neuroleptic medications not from Parkinsons disease affecting the limbs, head, mouth, or tongue; muscle rigidity, decrease in spontaneous facial expression, gestures, speech
- Neuroleptic Malignant Syndrome as described above: 30+% fatal

Medications to treat side effects (may be meds that would treat Parkinsons)
Cogentin (benztropine), Artane, Symmetrel, Akineton, Kemadrin, Benadryl

Other side effects may include allergic responses, skin rashes, cardiac EKG changes, liver changes, specific blood disorders which can be life threatening, endocrine changes such as prolactin.

Lesson Plan 8: Mood/Affective Disorders: Depression and Bipolar

I. Class Goals

Students will gain increased knowledge about mood disorders as a brain disease. Exposure to the signs and symptoms of these disorders will enable students to appreciate the challenges of this disease. Students will be exposed to risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this class students will be able to:

1. Recognize the symptoms of depression and mania
2. Articulate the risk factors associated with mood disorders
3. Practice interviewing a subject with a mood disorder to assess safety to self and others
4. Recall that mood disorders may have psychotic features

III. Methodology

Class will be taught using lectures, video examples and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "The Bridge"- "Chapter 6-Kevin Hines"

V. Content

See following page
PowerPoint "Depression Suicide"

MOOD DISORDERS/AFFECTIVE DISORDERS (General)

Moods fluctuate by nature; when moods interfere with functioning over time, they may become a diagnosed mood disorder

Your observation is one isolated glimpse of their "mood" history

Moods and range of affective expressions are normally in our control; with mood disorders, this control is lost

Mood disorders may be due to medical conditions or substance induced

Neurotransmitters (serotonin, norepinephrine, dopamine) are affected in mood disorders; hormones, such as growth hormone, prolactin, may also affect mood

Bias in diagnosis of mood disorders, eg clinicians tend to under diagnose mood disorders in cultural or racial backgrounds different from their own although mood disorders do not differ in racial prevalence

Medical conditions that can significantly affect mood:

- Parkinsons disease/ treatment of Parkinsons disease
- Cardiac disease
- Multiple sclerosis, lupus, i.e. autoimmune diseases
- Strokes
- Postpartum experience
- Cancer/chemotherapy
- Thyroid abnormalities
- Epilepsy
- Treatment with certain medications: blood pressure meds, steroids, prednisone, opiates, anti-inflammatory meds
- Migraines
- Vitamin deficiencies
- AIDS

DEPRESSION

Depression is a common feature of all mental illnesses, regardless of origin

Depression can mimic medical illness and significantly complicates the clinical picture for a person dealing with depression and another acute or chronic medical condition

Seen twice as often in females as in males

Symptoms of depression:

- Persistent sadness, emptiness
- Sleeping too much or too little, early morning waking
- Change in appetite

- Loss of interest, motivation
- Irritability
- Trouble with concentration, making decisions
- Fatigue, loss of energy
- Physical complaints
- Feelings of guilt, hopelessness, worthlessness
- Thoughts of death, suicide

Diagnosis of depression is made when mania or seasonal pattern is absent

Pre-existing factors may be: personality traits, environmental stressors, cognitive processes, such as learned helplessness, decrease in REM sleep

Seasonal affective disorder: depression associated with seasonal variation of light

Similar to ways sunlight affects seasonal activities of animals, eg hibernation, reproduction

Melatonin, a sleep related hormone, increases production in the dark, so when the days are shorter, the hormone increases

Phototherapy in light boxes, suppress the production of melatonin

MEDICATIONS FOR DEPRESSION

SSRIs: Serotonin Specific Reuptake Inhibitors making more serotonin available in the blood

- Begin to work right away, but take weeks to be effective and need a consistent treatment period of at least 6 months

Side effects of SSRIs:

- Nausea, GI distress
- Headache
- Insomnia
- Diarrhea
- Dizziness
- Tremors
- Ejaculatory dysfunction
- Decreased libido
- Constipation
- Rash
- Serious adverse reactions: suicidality, serotonin syndrome (toxicity)

Serotonin syndrome:

- Caused by too much of the serotonin meds, whether intentional or inadvertently mixed with other medications, eg SSRI with St. Johns wort, MAOI (monoamine oxidase inhibitors) an older form of anti-depressants increases serotonin when mixed with ecstasy(MDMA)

- Often mistaken for a virus, anxiety or worsening psychiatric condition
- Signs: confusion, agitation, headache, shivering, sweating, fever, muscle twitching, jerking, insomnia
- Can look similar to Neuroleptic Malignant Syndrome

SSRIs and similar meds: Prozac, Paxil, Zoloft, Celexa, Lexapro, Luvox, Effexor, Wellbutrin, Remeron- ***Risk - less lethal in overdose than older, tricyclic antidepressants (see below)***

May need other meds to cope with side effects, such as insomnia

Reasons a person may stop meds:

- Side effects
- Feeling better therefore not needing the meds
- lack of insurance and prohibitive cost

Tricyclic antidepressants :

- precede SSRIs, still used today, but sometimes at lower doses and for sleep rather than antidepressant effects

Side effects: sedation, dry mouth, constipation, blurred vision, palpitations

Serious side effects: hypotension, cardiac problems, including heart attack

Might see: amitriptyline, trazodone, desipramine, nortriptylin

Risk - HIGHLY lethal in overdose

BIPOLAR ILLNESS

Equal in men and women, 1% of US population (over 200 million Americans)

High percentage have relatives with depressive disorder of some type

Onset can vary: late 20s to early 30s, also can be diagnosed in children

Many types of bipolar illness which are based on most recent presentation, such as more manic, depressed, or mixed symptoms, severity of symptoms, and whether or not psychosis is present

Symptoms of mania

- Racing thoughts, rapid talking
- Excessive energy
- Decreased need for sleep
- Feeling 'high' euphoric
- Easily irritated
- Exaggerated confidence/grandiose ideas
- Periods of behavior different than usual: change in grooming, obsession with writing, collecting
- Poor judgments: spending sprees, reckless driving

- Unusual sexual drive
- Abuse of drugs
- Provocative, intrusive behaviors
- Denial that anything is wrong

Risks associated with bipolar illness:

High rate of suicide

dehydration

malnutrition

risk of STDs

financial loss

friends

provocative intrusive behaviors increase risk of harm from others

grandiosity may result in lack of judgment and increase risk taking

Manic presentation does not necessarily mean person has bipolar illness; may be substance induced, a medical condition, delirium. This can make bipolar illness difficult to diagnose.

Manic persons are at risk for medical complications, such as dehydration, malnutrition, high risk behaviors causing injuries

Medications to treat bipolar illness can be challenging:

- causes risks on the kidneys and liver
- requires frequent blood level monitoring
- reduces the sense of euphoria

MEDICATIONS FOR BIPOLAR ILLNESS

☐ Antidepressants, previously discussed, are used for the depressive phases of bipolar illness

☐ LITHIUM: hallmark medication although this may be incompatible with some people

o Side effects: tremors, increased urination, thirst, diarrhea, nausea, vomiting, muscle weakness, weight gain

o Requires lab monitoring of lithium level, kidney and thyroid function

o Lithium may not be effective alone in severe illness

o May require adjunctive medication with its own set of side effects

Risk -- toxicity

☐ ANTICONVULSANTS (seizure meds)

o DEPAKOTE (valproic acid): requires lab monitoring, tolerated fairly well
Side effects: tremors, hair loss, weight gain, blood dyscrasias

o TEGRETAL (carbamazepine): requires lab monitoring for liver problems

Side effects: sedation, nausea, blurred vision, ataxia, allergic rash

- o LAMICTAL (lamotrigine): similar side effects, serious adverse reaction of rash
- o GABATRIL, TOPAMAX, TRILEPTAL, NEURONTIN: other meds used for bipolar illness/mood stabilization
- ATYPICAL ANTIPSYCHOTICS are now approved for treatment of acute mania in bipolar illness:
 - o Zyprexa, Seroquel, Abilify, Geodon,
- OTHER AGENTS: Clonazepam, clonidine, clozapine, verapamil

Lesson Plan 9: Suicide

I. Class goals

Students will gain increased knowledge about the prevention and intervention associated with a suicidal subject.

II. Performance Objectives

Upon completion of this course the student will be able to:

1. Describe those who are at risk for suicide
2. Describe the risk factors that lead people to suicide
3. Articulate the possible motivations for suicide
4. Recall specific interview questions for a suicidal subject

III. Methodology

Class will use lectures and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens

V. Content

PowerPoint "Depression suicide"

Lesson Plan 10: Anxiety Disorders (general)

I. Class Goals

This class will help students recognize and differentiate anxiety as a normal response to stressful events as opposed to a mental health disorder. Students will be exposed to a risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this class students will be able to:

- 1) Recognize various types of anxiety disorders
- 2) Describe the difference between normal stress and anxiety as a mental disorder
- 3) Articulate the risk factors associated with anxiety disorders
- 4) Practice utilization of outside resources

III. Methodology

Class will be taught in lecture format with the use of video analysis

IV. Materials and equipment

- 1) Projector and screen
- 2) DVD Player
- 3) Flip Chart and Pens

V. Content

(See following page)

ANXIETY DISORDERS

- Anxiety serves us well generally: an alerting signal, warning of impending danger
- threats of bodily harm, pain, punishment
- May be barrier to success
- Effects on bodily functions, social interactions
- Assists in taking steps to lessen the consequence, prevent the threat

Differs from fear in that fear alerts us to known external threats

Two parts of the brain shape our anxiety and fear:

1. Amygdala:
 - a. Almond-shaped structure deep in brain, is the go between in the parts of the brain that processes and helps interpret incoming sensory signals; alerts the brain that a threat is present
 - b. Appears to store emotional memories
 - c. May play a role in specific fears, phobias
2. Hippocampus: also deep in the thalamus, encodes events into memories

Anxiety disorders are THE most common mental illness in America

About 40 million adults; although they occur in children and adolescents as well

Frequently a co-occurring disorder with other conditions, such as addiction disorders, as well as medical conditions, heart disease, Alzheimers, tumors, hyperthyroid

Alcohol use disorders are 3 to 4 times more prevalent in persons with anxiety disorders
*Risk - can decrease impulse control and judgment. **Very lethal in overdose when combined with medications used to treat anxiety.***

Medications can cause anxiety: antipsychotics (akathisia); thyroid meds, bronchodilators, anticholinergics (cold medicine), hormonal therapy, some anti-hypertensives

Physical response to anxiety:

1. Increased respiration, heart rate, blood pressure
2. Palpitations, sweating, tremors
3. Nausea, diarrhea
4. Urinary frequency, urgency
5. Dizziness, fainting

Becomes pathological, “diagnosable” when it incapacitates one's functioning, and is of duration and frequency

MEDICATIONS FOR ANXIETY DISORDERS

Medications are only one part of treatment; psychotherapy is key

Cognitive behavioral therapy: changes the thinking that supports the anxiety as well as their behavioral reactions to the anxiety

Exposure-based behavioral therapy is used in specific phobias

Anti-anxiety medications: primarily benzodiazepines and generally prescribed for short term;

Side effects of benzos: sedation, ataxia, confusion, with toxicity: respiratory depression

Beta-blockers: routinely used for hypertension, can prevent/reduce the physical symptoms of anxiety, eg. Used before public speaking

Side effects of beta-blockers: dizziness, a slowed heart beat, fatigue, low blood pressure

SSRIs (prozac, paxil, Zoloft, celexa, lexapro, etc) are used particularly with OCD and PTSD

Side effects: gastric distress, nausea, headache, sexual dysfunction and caution of the serotonin syndrome (confusion, sweating, stiffness, increased blood pressure and heart rate)

Lesson Plan 11: PTSD/PTSD & VETS

I. Class Goals

This class will expose students to people at risk for PTSD, signs and symptoms of PTSD, and risk factors associated with PTSD. Special focus will be given to war veterans and PTSD. Students should gain awareness that first responders are especially susceptible for developing this disorder.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Describe signs and symptoms of PTSD
2. Describe who may be at risk for developing PTSD
3. Recall PTSD risk factors specific to war veterans
4. Know how to utilize local resources for vets
5. Recognize that officer has an increased chance of PTSD due to the nature of police work

III. Methodology

Class will utilize a combination of lecture (PowerPoint), video and discussion.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "Frontline: A Soldier's Heart"

V. Content

See following page

POST-TRAUMATIC STRESS DISORDER

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder. Occurs after a traumatic event. A traumatic event = something horrible and scary that you see or that happens to you. You believe your life or others' lives are in danger.

Anyone who has gone through a life-threatening event can develop PTSD. These events can include:

- Combat or military exposure
- Child sexual or physical abuse
- Terrorist attacks
- Sexual or physical assault
- Serious accidents, such as a car wreck.
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake.

How does PTSD develop?

All people with PTSD have lived through a traumatic event that caused them to fear for their lives, see horrible things, and feel helpless. Strong emotions caused by the event create changes in the brain that may result in PTSD.

Most people who go through a traumatic event have some symptoms at the beginning. Yet only some will develop PTSD. It isn't clear why some people develop PTSD and others don't.

Development of PTSD depends on:

- How intense the trauma was or how long it lasted
- If you lost someone you were close to or were hurt
- How close you were to the event
- How strong your reaction was
- How much you felt in control of events
- How much help and support you got after the event

Symptoms of PTSD:

Symptoms of posttraumatic stress disorder (PTSD) can be terrifying. They may disrupt your life and make it hard to continue with your daily activities. It may be hard just to get through the day.

PTSD symptoms usually start soon after the traumatic event, but they may not happen until months or years later. They also may come and go over many years.

PTSD likely if:

- Symptoms last longer than 4 weeks;
- Cause you great distress;
- Interfere with your work or home life.

Four types of symptoms: Re-experiencing, avoidance, numbing, and hyperarousal

PTSD AND VETS

Involved in combat = high potential of exposure to life-threatening experiences

PTSD occurs:

- 30% of Vietnam veterans
- 10% of Gulf War (Desert Storm) veterans
- 6% to 11% of veterans of the Afghanistan war (Enduring Freedom)
- 12% to 20% of veterans of the Iraq war (Iraqi Freedom)

Other factors that may contribute to PTSD and other mental health problems:

- Role in the war
- Politics around the war
- Where the war is fought
- Type of enemy you face

Lesson Plan 12:
Police Officer Holds (POH), Director's Custody Holds,
Emergency Departments, and the
Civil Commitment Process

I. Class Goals

This class will review Police Officer Holds and Director's Custody Holds in Multnomah County. The class will also familiarize officers on emergency room protocols regarding holds. This class will introduce and review the civil commitment process.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recall the difference between a POH and a Director's Custody Hold
2. Recognize emergency department procedures and protocols
3. Describe the steps in the civil commitment process
4. Articulate the importance of a detailed report for the purposes of a hold

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and deliver the information in lecture format with a question and answer period.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector/Computer with PowerPoint

V. Content

See following page
See PowerPoints

REQUIREMENTS OF A POLICE OFFICER HOLD (POH)

- Probable cause that the person is a danger to self or others and is in need of immediate care
- Due to mental illness
- POH allows police officer to transport person to the hospital or other appropriate care facility. (In Multnomah County there is no facility that only receives psychiatric patients such as the former Crisis Triage Center).
- 72 hour holds no longer exist and haven't for many years

Putting someone on a hold is a legal decision.

WHO CAN PUT A HOLD ON SOMEONE?

- Police Officer Hold (POH): The POH allows officers to put a **civil** hold on someone who is deemed a danger to self or others. It allows officers to transport the individual to a medical/psychiatric facility for further evaluation.
- Qualified Mental Health Professionals (QMHP) who have undergone training and have been certified by Multnomah County's Mental Health and Addiction Services Division. When a QMHP places a hold on someone they do this under the authority of the county mental health director, hence the term "Director's Hold." ORS states that a person placed on a Director's Hold **shall** be transported by law enforcement to the nearest hold facility.
- Most therapists, psychiatrists, psychologists, and counselors do not have the authority to place a hold on someone.

HOSPITAL EMERGENCY DEPARTMENTS

- Not all hospitals take people on a mental health hold
- All hospitals in our area (save the old Woodland Park) take people on holds
- Hospitals need to be authorized/certified by the state to accept psychiatric patients

WHAT HAPPENS AT THE HOSPITAL?

- The mentally ill person will be evaluated by the emergency department doctor and/or a social worker. The decision to "hold" the person in the ED is made by a doctor in the ED.
- Hospital staff uses the same criteria that police do --danger to self or others due to a mental illness.
- **Or**, a hospital hold can be placed (essentially a continuation of the police officer hold) which means the person stays in the hospital for now.
- If a hospital hold is placed, client is transferred to a hospital unit; this may or may not be at the same hospital where client was taken on the hold. Much depends on bed availability. The person can be held for up to 72 hours at this point.
- **Or**, the hold can be "dropped," meaning the ED doctor determined that the person is no longer a danger to self or others. The person will be discharged from the hospital.

CIVIL COMMITMENT PROCESS

- Once a hospital hold is placed, Multnomah County Mental Health is alerted. An ICP (Involuntary Commitment Program) investigator is assigned from Multnomah County Mental Health. The ICP interviews client and attending staff in the hospital. The ICP also uses previous hospital records, family, friends, caseworkers, police reports etc. to evaluate whether the person meets the "danger to self or others" criteria.
- The ICP can:
 - Continue the hold and set a hearing date for civil commitment
 - Drop the hold (the person gets discharged asap)
 - Let the hold run out (maximum of five business days)
- The determination to take the person to a civil commitment hearing occurs within 3 business days of the hold.
- The ICP sets a hearing date for the mentally ill person for no longer than 5 business days from the date the hold was written.
- The hearing can be set over for an additional week. Practically speaking, this option only occurs if the mentally ill person is participating in treatment (usually taking meds.)
- The client may also elect to stay in the hospital voluntarily, if agreed upon by medical staff.

Remember: civil commitment is a legal process, not a clinical one. It has been designed as a legal procedure. At times, the logic of the legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of the family, significant others, or treatment providers.

AT THE HEARING

- If the client has a commitment hearing, he/she could be committed for up to 180 days (average commitment is 2-3 weeks).
- **OR** he/she could be released from court
- **OR** he/she could "stipulate" thus voluntarily returning to the hospital
- **OR** he/she could have a "setover" which would send the client back to the hospital until the next week, after which they would return to court to be re-evaluated.
- Present at the hearing are: Two mental health professionals take part in the hearing (usually a psychiatrist and psychologist), in addition to reports from the ICP, witnesses, and a judge who makes the final determination for commitment.

TWO-PARTY PETITION

- A "two-party petition" can be initiated/signed by any two adult members of the community who deem the person in question is unable to meet their basic needs. The "two-party petition" is used for issues of what is called "inability to care" or "deterioration of function." The petitioners must have first hand evidence of the person's lack of ability to care for him or herself. They must also be willing to testify in court.

- The petition is filed at the county's mental health division.
- The person in question remains in the community while the details of the petition are being investigated.
- The investigation is completed within fourteen calendar days.

NOTE:

The term "chronically mentally ill" is defined as followed:

- A. Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility.

AND

- B. Is exhibiting symptoms or similar behaviors to those that preceded or led to one or more hospitalizations or inpatient placements.

AND

- C. Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Lesson Plan 13: Delirium and Excited Delirium

I. Class Goals

This class outlines the signs and symptoms of delirium and excited delirium. Protocols and procedures for dealing with subjects exhibiting signs of excited delirium will be presented.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recognize signs and symptoms of delirium
2. Recognize signs and symptoms of excited delirium
3. Describe procedures for dealing with a subject suspected of being in a state of excited delirium
4. Articulate that delirium and excited delirium are **medical emergencies** requiring swift medical intervention

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. PPB Training Video (March, 2008) if applicable

V. Content

See following page

DELIRIUM

- A *syndrome* and not an ongoing disease

Medical/organic cause:

- Epilepsy/postictal states
- Infection, frequently urinary tract, particularly in older person
- Fluid/electrolyte imbalance, dehydration
- Head trauma
- Stroke
- Medication interaction
- Drug induced
- Alcohol withdrawal
- Extreme hypothermia
- Liver failure
- Kidney failure

Symptoms:

- Perceptual disturbances: visual hallucinations
- Reduced consciousness, unaware of environment
- Highly distractible
- Rambling incoherent speech- may come and go
- Increase or decrease in psychomotor activity
- Disoriented to place, person, and time
- Onset usually sudden, over hours or 2-3 days
- Sleep/wake cycle disturbed
- Immediate memory is impaired

Delirium is a medical emergency

EXCITED DELIRIUM

- See attached PowerPoint
- PPB Training Video (March, 2008) on excited delirium for all Advanced Academy classes starting in 2009.

Lesson Plan 14: Personality Disorders

I. Class Goals

This class will introduce students to the DSM-IV. Specifically, it will underscore the difference between an Axis I and an Axis II disorder. The concept of an Axis II disorder will help students understand why certain behaviors, although maladaptive and potentially dangerous, do not result in a hospital hold. Four personality disorders that officers are most likely to encounter will be discussed.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Articulate the difference between an Axis I and an Axis II mental health disorder.
2. Recognize the specific challenges of interacting with individuals with a personality disorder.
3. Utilize appropriate techniques to most effectively communicate with individuals with a personality disorder.

III. Methodology

This class will utilize a combination of lecture (PowerPoint) and discussion.

Materials and equipment

1. Projector with PowerPoint slides
2. Flipchart with pens

IV. Content

See attached PowerPoint slides

Lesson Plan 15: Psychiatric Security Review Board

I. Class Goals

This class will familiarize students with the function of the Psychiatric Security Review Board (PSRB). Examples of a LEDS PSRB "hit" will be shown so students will be prepared to follow proper procedures should they encounter a PSRB client in need of services.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recognize a LEDS PSRB "hit" on the MDT
2. Follow appropriate protocols for a PRSB detention order
3. Describe the role of PSRB in the mental health and justice system
4. Articulate the meaning and consequences of being found "guilty except for insanity" (GEI)

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Consumer video: "Ashleigh"

V. Content

See PowerPoint

Lesson Plan 16: “Hearing Voices” Exercise

I. Class Goals

Through this interactive exercise, students will gain an appreciation of the challenges of living with some of the symptoms of schizophrenia.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Identify symptoms of schizophrenia
2. Recognize the challenges of interacting with police officers while experiencing auditory hallucinations
3. Practice communication techniques when interacting with someone who seems “distracted” due to possible psychotic symptoms

III. Methodology

Description of exercise:

Instructors will demonstrate the exercise using volunteers from the class. Then the class will break up into groups of four with the following roles for each of the four participants:

1. “Psychotic” person in the middle of two participants
2. One person on one side of the “psychotic” person
3. One person on the other side of the “psychotic” person
4. One person who interviews the “psychotic” person

Person #1 will sit in a chair. The person needs to remain seated during the exercise. They will listen and try to answer any questions directed at them.

Person #4 will have a list of questions to ask the seated person. He/she will ask familiar ones such as: name, D.O.B., and other, more complicated questions that require higher levels of thinking. This person will stand directly in front of the seated person.

Person #2 and #3 will stand on each side of the seated person, with a “voices” script. They will also get a piece of paper and roll it up into a tube, making a “mini-megaphone.” They will then put the tube about 1-2 inches from the seated person’s ears and start talking in a low voice. They will talk faster and slower as needed. They can also talk louder and softer as they see fit. If participants are familiar with each other, they can vary the “script” accordingly. Participants switch positions so all class members can experience the challenges of communicating while “hearing voices.” The exercise is debriefed afterwards.

Materials and equipment

1. Projector with slides of the two scripts
2. Copies of voices scripts

3. Card stock paper or similar material to create a "megaphone."

IV. Content

PowerPoint of "Scripts"

Lesson Plan 17:
Mental Retardation/Developmental Disabilities

I. Class Goals

This class will familiarize students with the definition of "MRDD." Communication techniques for this population will also be reviewed.

II. Performance Objectives

Upon completion of this class the student will be able to:

1. Define "developmental disabilities" as it is used in Multnomah County
2. Differentiate between people with MRDD issues and people diagnosed with a mental illness
3. Describe appropriate communication techniques for the MRDD population
4. Articulate how interviewing a person with MRDD issues differs from interviewing people outside the MRDD population

III. Methodology

Class will utilize a flipchart, PowerPoint presentation, video and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Video: Dave Dobler

V. Content

See following page

1. Many causes of brain dysfunction
 - i. Anatomical abnormality or damage e.g. trauma, tumors, electrocution
 - ii. Lack of oxygen/glucose: diabetes, stroke, asphyxiation
 - iii. Electrolyte imbalance: dehydration
 - iv. Neurotransmitter dysregulation: dopamine (thought organization)
 - v. Norepinephrine (fight/flight, focus, alertness)
 - vi. Serotonin (mood states)
 - vii. Acetylcholine (memory, inhibition)
 - viii. GABA (reduces arousal, aggression, anxiety)
 - ix. Endorphins (pain, stress response)
 - x. Viral
 - xi. Genetic
 - xii. Autoimmune
 - xiii. Substance abuse
 - xiv. Nutritional
2. Developmental Disabilities
 - i. 220 DD disorders
 - ii. Can be genetic, congenital, environmental
 - iii. 2% of Multnomah County (approx. 15,000 people)
3. DD differs in cause from mental illness
 - i. Childhood diagnosis
 - ii. IQ affected
 - iii. Lifelong prognosis
 - iv. Medications do not change functionality
4. Communication principles and techniques
 - i. Patience, patience, patience
 - ii. Ask if person has a hearing or other disability
 - iii. Ask how accommodation might be made
 - iv. Talk clearly and slowly
 - v. Repeat yourself if needed
 - vi. Offer to have a family member/friend present at the interview
 - vii. Understand the person's need to "please"
 - viii. Set appropriate boundaries, if needed

Lesson Plan 18: Addictions and Mental Health

I. Class Goals

This class will familiarize students with the physiological and psychological effects of drugs and alcohol. The class will cover the concept of "dual diagnosis" and will outline the unique challenges of treating both substance abuse/dependence and mental illness.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Articulate the meaning of "dual-diagnosis"
2. Describe the physiological effects of various drugs, including alcohol
3. Appreciate the challenges involved in the process of recovery (i.e. relapse)
4. Familiarize students with addiction resources in the community
5. Recognize the role that officers can play in the recovery process

III. Methodology

Class will utilize a flipchart, discussion, supporting handouts, and video

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Video: HBO "Addictions" Disk One: The Science of Relapse

V. Content

See handout

CHALLENGING ISSUES IN THE TREATMENT OF MENTAL ILLNESS

There are both internal and external barriers to treatment within the mental health system. We will address both:

Internal Issues:

- On the internal problems, one of the most significant is STIGMA: a labeling process which sets a person apart from others. For the mentally ill, it has severe consequences; it can be the primary reason a person does not seek treatment
- Where does this stigma come from? Fear, assumptions, family teachings, the media, jokes, rigid beliefs, intolerance
- *Activity: Brainstorm stereotypes of people with mental illness on a flip chart*

External systemic issues:

- The media can perpetuate stigma yet can also help overcome the stigma (ex: "Snake Pit" helped bring awareness to psychiatric institutions and their lack of treatment); it can start with individuals, something as simple as not laughing at a joke which stigmatizes someone
- There is a need for mental health providers to include the effects of stigma on the person in their treatment plans
- Of all the "isms" there is not one for discrimination against the mentally ill
- Language matters! For example, "12-34." Understand the need for shorthand in communicating a police call but need to be aware of its effects and the potential for helping to perpetuate the stigma
- Insurance has and continues to be biased against the mentally ill; only in Jan. 2007 has Oregon initiated parity for mental illness (services for mental illness get reimbursed at the same rate as physical illnesses such as heart disease and diabetes)
- Cultural factors: Mental illness is viewed differently in different cultures
- Providers may have "compassion fatigue." Caseloads may be unreasonably high
- Empowerment is essential to recovery, yet sometimes clinicians lose sight of hope and the concept of recovery
- ACCESSIBILITY ISSUES:

- Insurance
- Eligibility requirements
- Lack of privacy
- Payor system for providers is constantly changing
- Medication coverage is inconsistent
- Younger persons experiencing the onset of their illness are unlikely to be hospitalized long enough to experience remission of symptoms
- Homelessness offers specific challenges on top of those already mentioned:
 - 1/3 of homeless mentally ill nationwide
 - Shelter requirements i.e. TB card
 - Medications can put one at risk i.e. drowsy, victimization
 - Lack of accessibility due to no housing address, contact info etc
 - Loss of benefits due to symptoms of disorganization
 - Inability to track appointments due to symptoms of disorganization
 - Increased exposure to health problems i.e. dependent positioning

Project Respond

I. Class Goals

This class will outline the various services provided by Project Respond

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Know how to access Project Respond's 24/7 crisis team
2. Recognize Project Respond procedures and protocols
3. Recognize the other programs within Project Respond that might be helpful for following up with subjects
4. Recall under what conditions Project Respond requests police
5. Determine when it is appropriate to call Project Respond

III. Methodology

Class will utilize a flipchart and deliver the information in lecture format with a question and answer period

IV. Materials and Equipment

Flip Chart and pens

V. Content

See following page

PROJECT RESPOND

1. Began in 1993 to provide homeless outreach and crisis response to persons with mental illness in the downtown area; responded to calls from consumers, police, family members, businesses, and social service agencies
2. Today Project Respond is 24/7 , county wide, available through police dispatch and the Multnomah county crisis line; PR carries pagers only accessible through dispatch
3. Services available through Project Respond:
 - On site assistance with crisis, if further evaluation is indicated
 - Follow up engagement visits or welfare checks if officer deems appropriate
 - Outreach to homeless individuals
 - Assist case managers with checking on their clients
 - Implement Directors Custody Holds requesting police for transport to ED
 - Provide community education to community agencies, landlords, security personnel, businesses
 - Assist emergency rooms in connecting persons to resources (those who do not meet hospitalization criteria)
 - Provide welfare checks to residents when requested by landlords (those who may be experiencing symptoms of mental illness)
 - Respond to crisis involving children and families; provide follow up support visits by specialized Child/Family team through PR
 - When culturally specific concerns are present, PR utilizes cultural specialists to address both the clinical and cultural issues and to ensure that the interventions are culturally appropriate; PR has the following cultural specialists:
 - i. Eastern European
 - ii. African American
 - iii. Asian American
 - iv. Native American
 - v. Hispanic
 - Can provide phone consultation to officers if requested and no PR on site presence indicated
4. IF POLICE REQUESTING PROJECT RESPOND:

- Page Project Respond through dispatch; if possible, providing information re: subject, DOB if available. This assists PR in potentially obtaining pertinent clinical information.
- Project Respond will provide dispatch with cell phone by which officer can contact PR if needed while PR in route to call
- Upon arrival, PR will consult with officers re: situation, and precede with assistance with subject
- PR may also be called or paged for consultation if no immediate face-to-face intervention is warranted
- Police may also request follow up engagement or welfare check on subject; it is possible that PR will request police to accompany them on this visit if this seems warranted

5. IF PROJECT RESPOND REQUESTING POLICE:

- Project respond will call for police through dispatch providing information re: the reason for assistance and name of client
- If known, PR will provide information re: history of violence, any known weapons, presence of others (or pets) in the environment, and size and presentation of client
- PR will also provide information re: PR whereabouts and cell phone number as PR frequently does not park in front of location
- PR will further brief officers upon their arrival and discuss plan for assessment
- If hold is deemed necessary, PR will request the police transport client to hospital and provide transport officer with Hold form
- Generally, PR accompanies police and client to hospital in order to brief the hospital staff

brain

Perceptions
Senses

AFFECT

Judgment

Speech

Orientation

Thought
Content

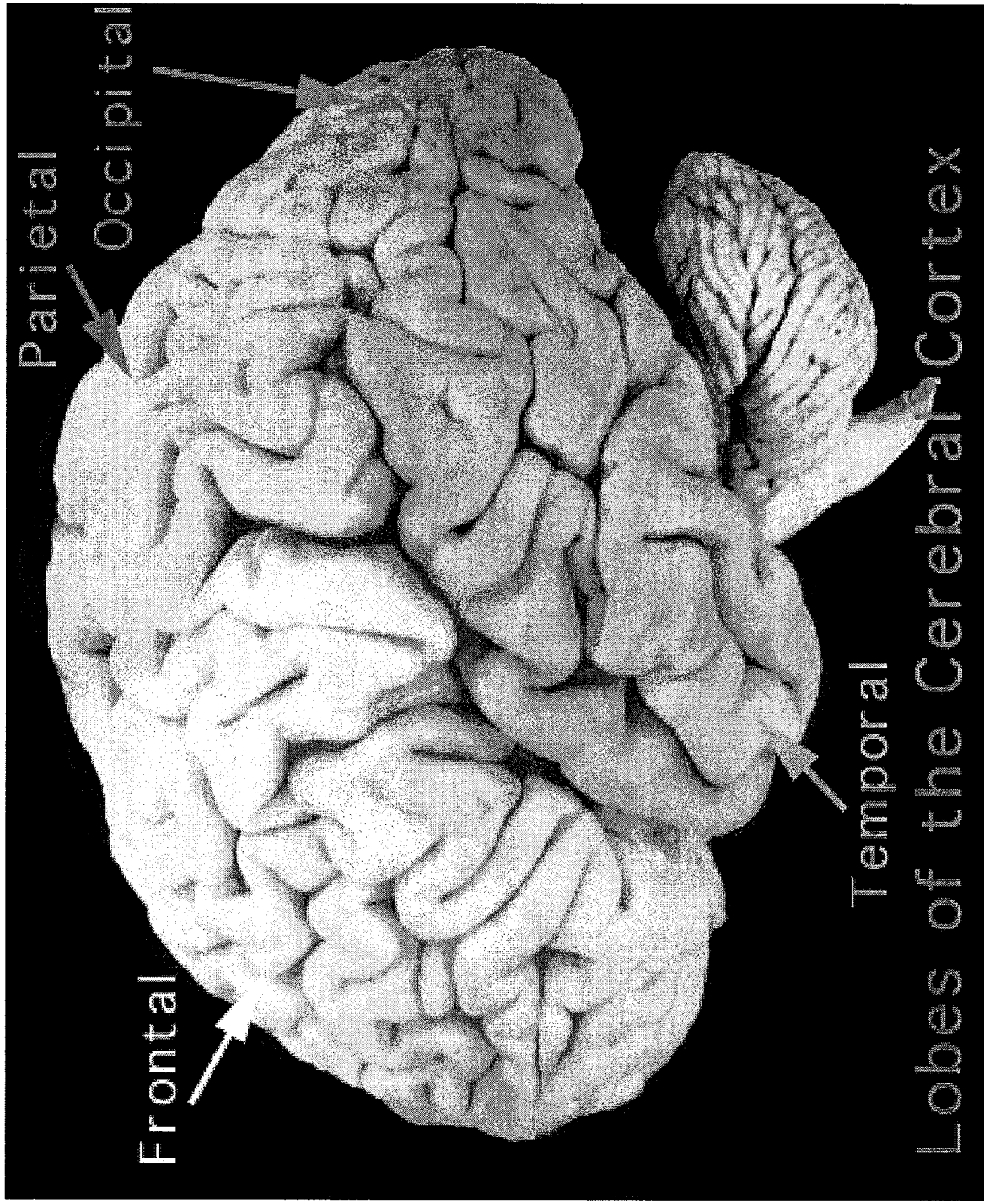
Language

Motor Activity

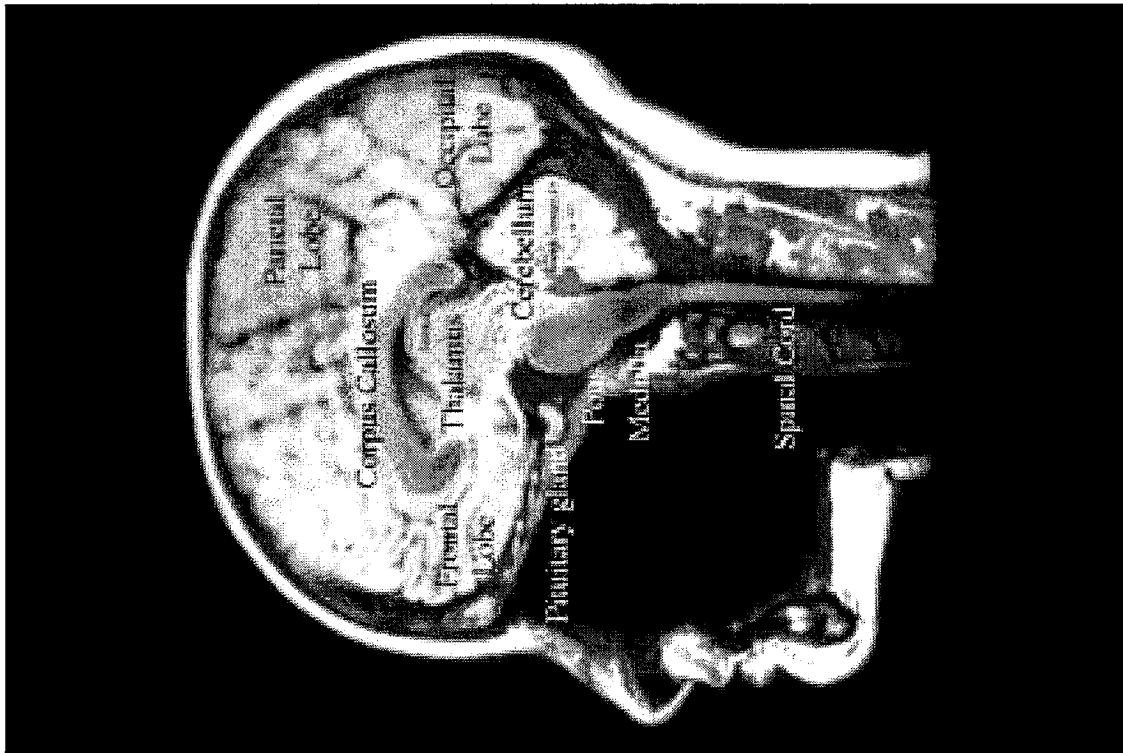
Memory

Insight

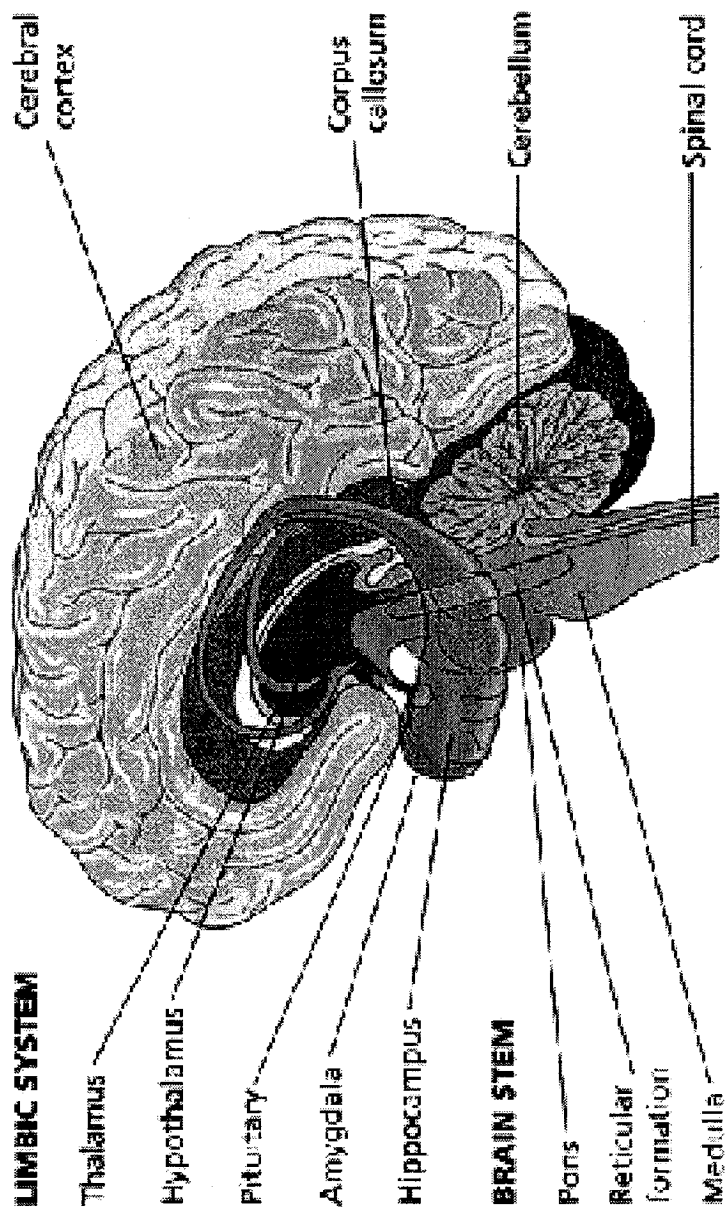
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Feb07-Dec08



Feb07-Dec08



Feb07-Dec08

Or...., What's Going On In There?



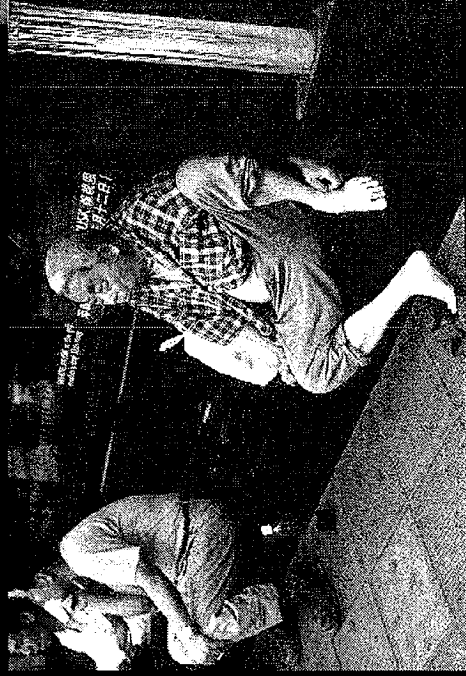
Feb07 Dads

Components of the MSE

- General Appearance
- Thought Content
- Thought Process
- Speech
- Mood/Affect
- Psychosis
- Cognition

General Appearance

- Clothing
 - Appropriate for weather?
 - Appropriate for context?
 - Style?
 - Cleanliness?



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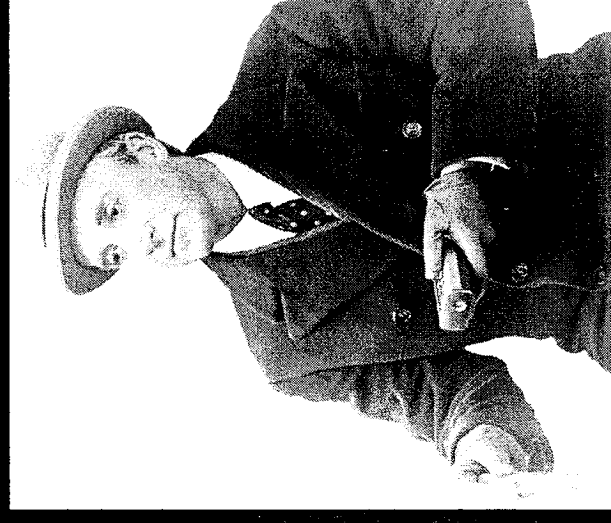
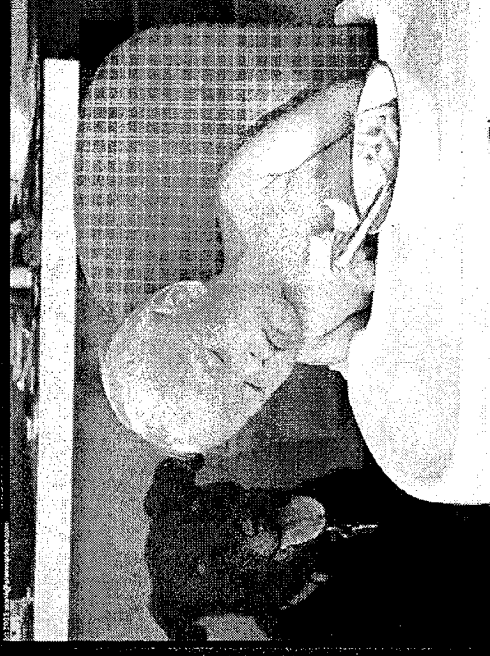
General Appearance

- Hygiene
 - Personal
 - Dental
 - Environmental
 - Clothing



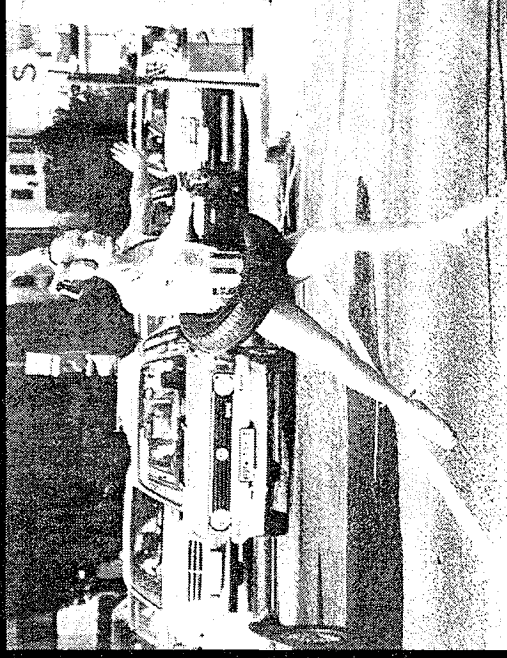
Cognition

- Level of alertness
 - Conscious, sedated, etc.
- Orientation
 - Person
 - Place
 - Time
 - Situation



General Appearance

- Behavior
 - Goal-Directed/Organized?
 - Appropriate for context?
 - Speed?
 - Response from others?
 - Co-operative?



Speech

- Speed
- Pressure
- Abnormal Words
 - Nonsense words
 - Neologisms

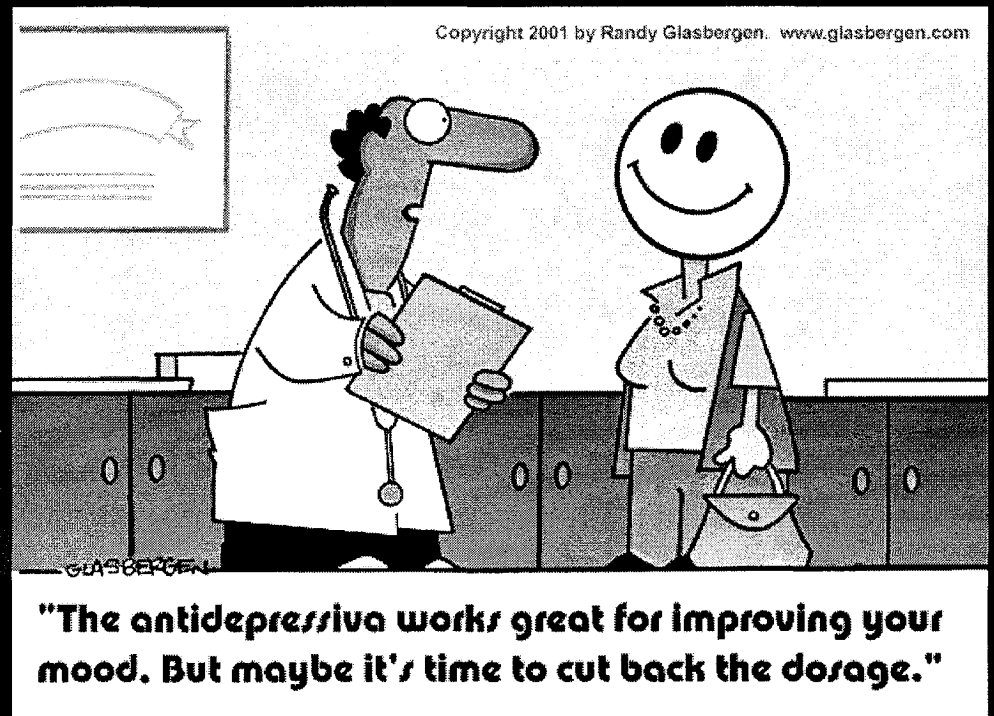
Mood/Affect

- Mood
 - How the person says he/she is feeling)
 - *Subjective* evaluation



Mood/Affect

- Affect
 - How the person *appears* to feel
 - *Objective* evaluation



Thought Content

- *What* is the individual saying?
 - Delusions (of persecution, grandeur, conspiracies, etc.)
 - Relevancy to situation
 - Perseveration

Thought Process

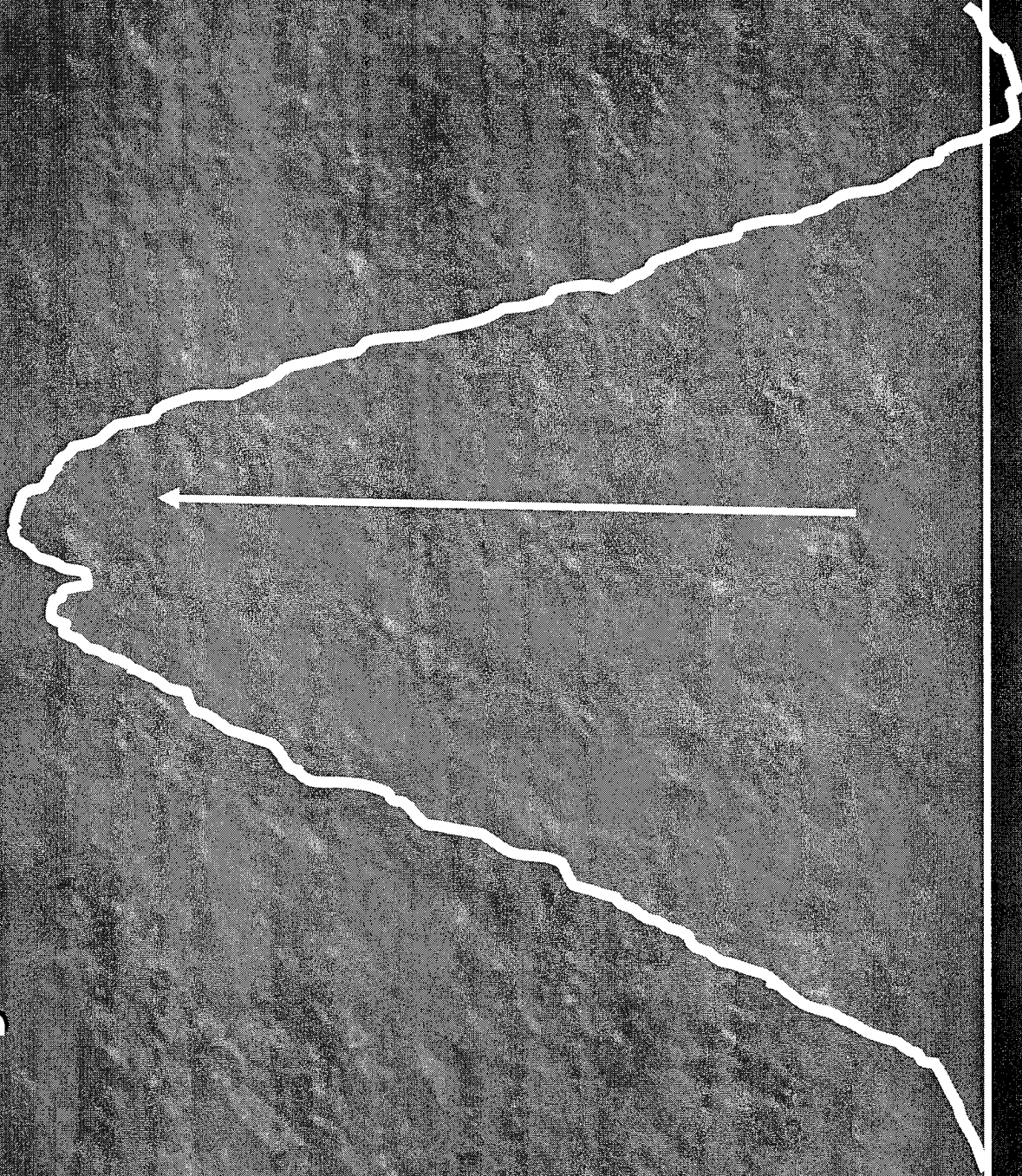
- *How* is the individual saying it?
 - Organization (e.g. circumferential, tangential, loose associations, flight of ideas, word salad, etc.)
 - Thought Blocking (i.e. long pauses during talking)
 - Perseveration

Perceptual Disturbance

- Hallucinations
 - Auditory –(hears voices)
 - Visual –(sees things that aren't there)
 - Tactile –(feels things that aren't there)
 - Gustatory –(taste)
 - Olfactory –(smell)
- Responding to internal stimuli

Crisis Cycle

Crisis



Baseline

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What is a crisis?

Something has happened and it's
overwhelmed a person's ability to cope,
in that moment, for whatever reason



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**Not every mental illness is a crisis;
Not every crisis involves mental illness.**

Mental "Moments"

**Mental Moments = No diagnosis but behavior
that is far from rational**



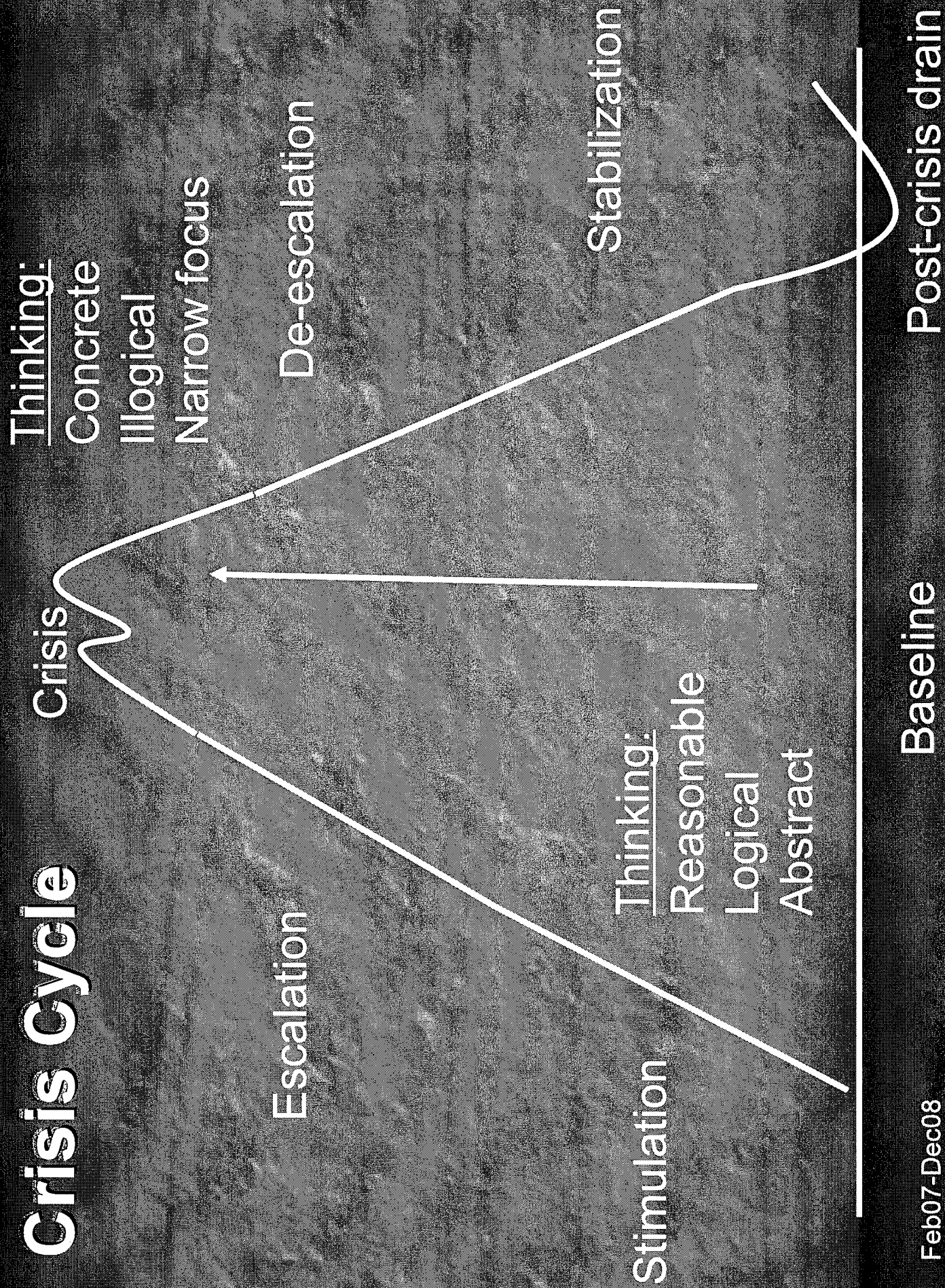
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Examples of Mental “Moments”

- Road Rage
- Grief
- Traffic Accidents
- Riots
- Frustration/Anger
- Natural disasters

***Where ever people are freaking out and don't
respond to normal communication**

Crisis Cycle



Crisis Cycle

Crisis

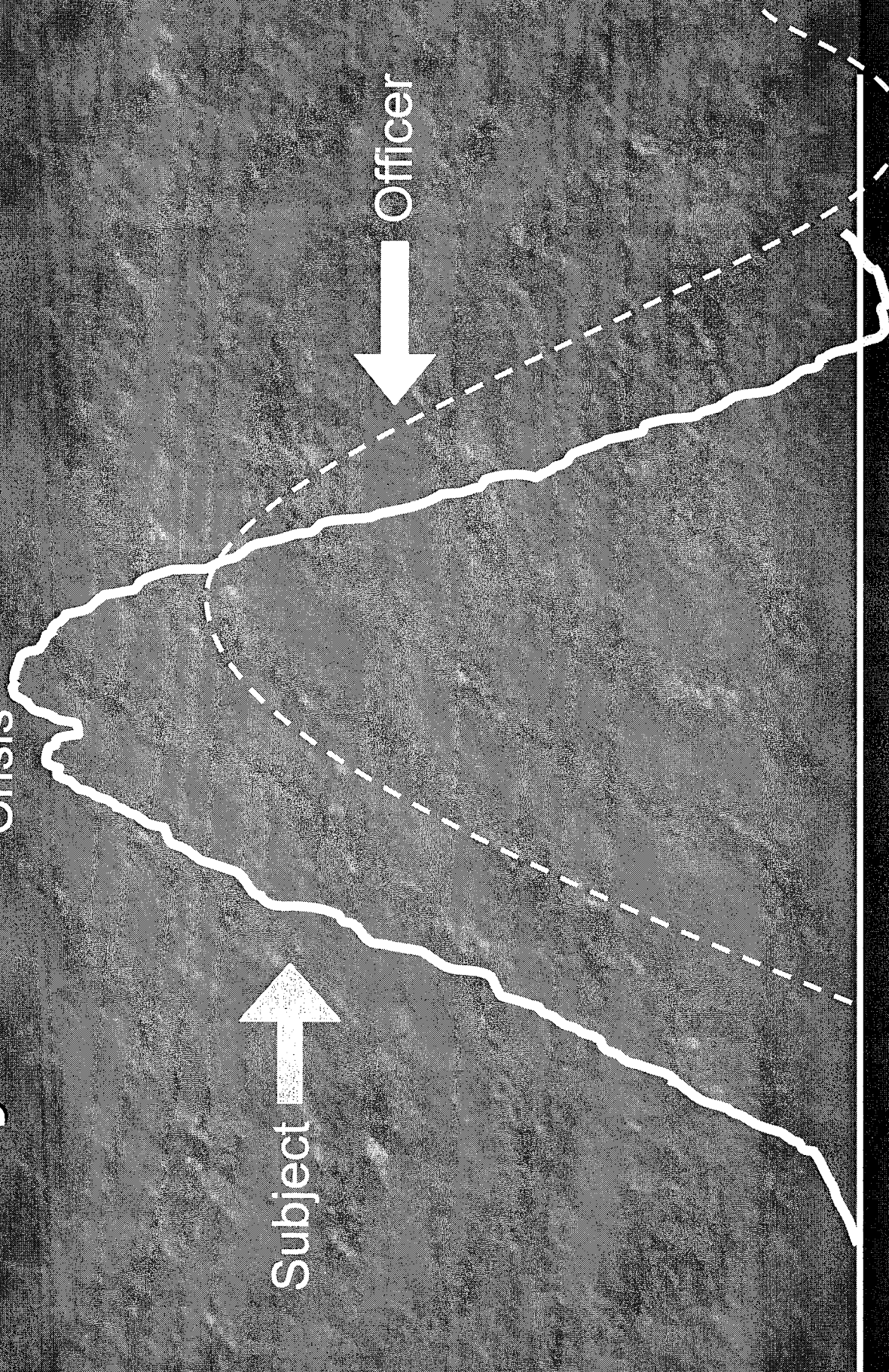
Subject ↑

↓ Officer

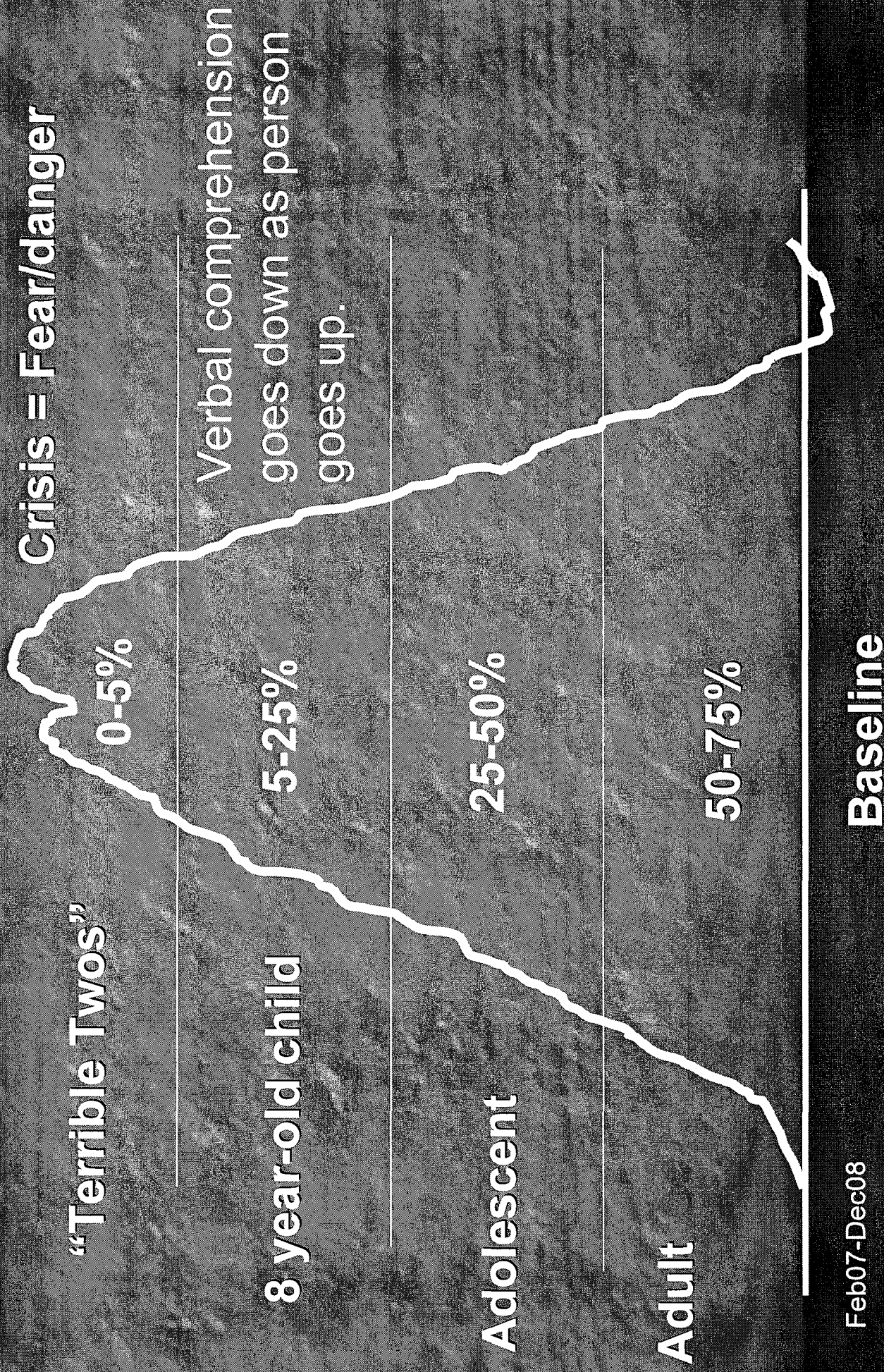
Baseline

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Post-Crisis



Communication



Crisis Cycle

Crisis

Thinking:
Concrete
Illogical
Unfocused

Escalation

De-escalation

Stimulation

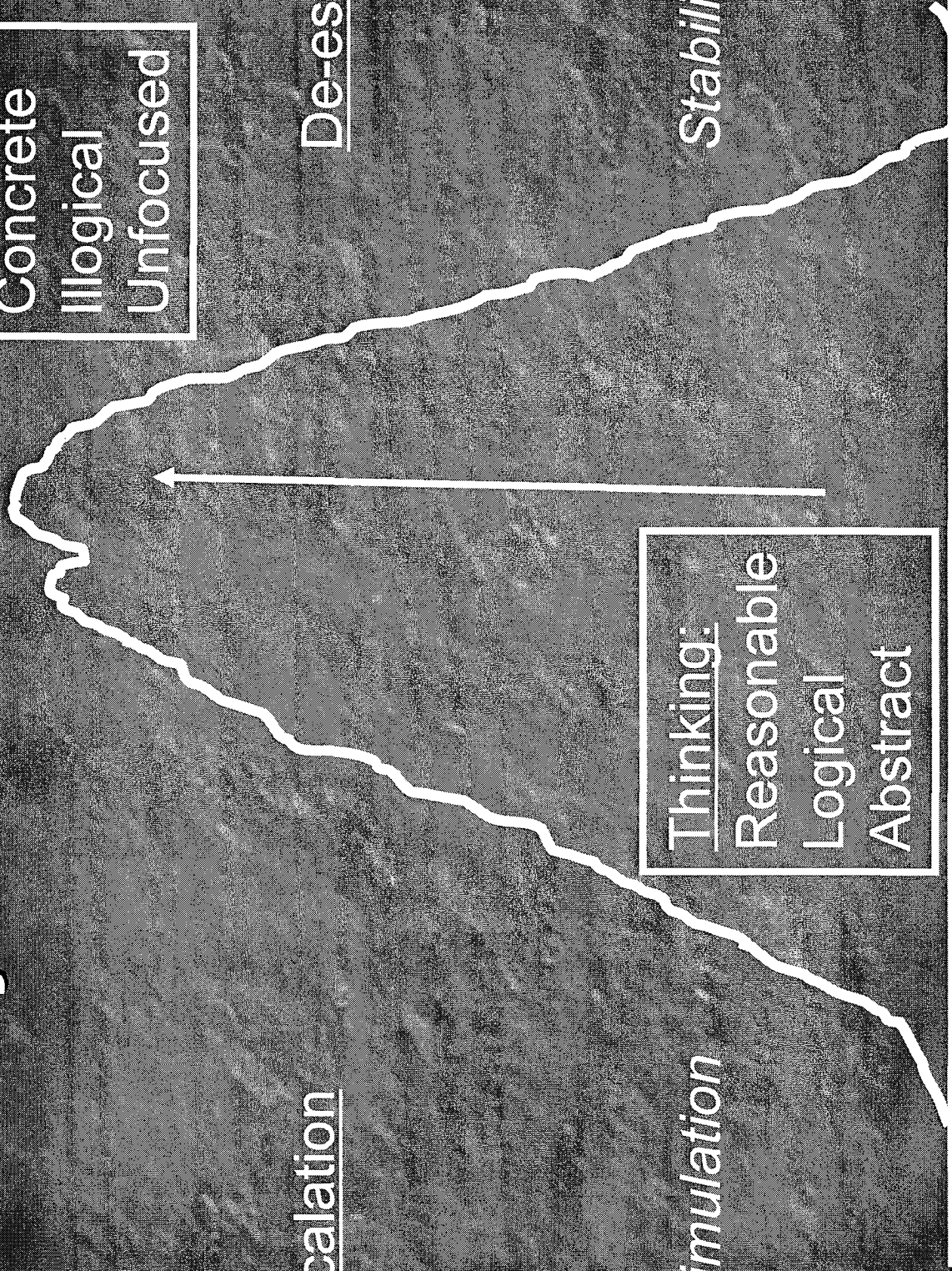
Stabilization

Thinking:
Reasonable
Logical
Abstract

Baseline

Post-crisis drain

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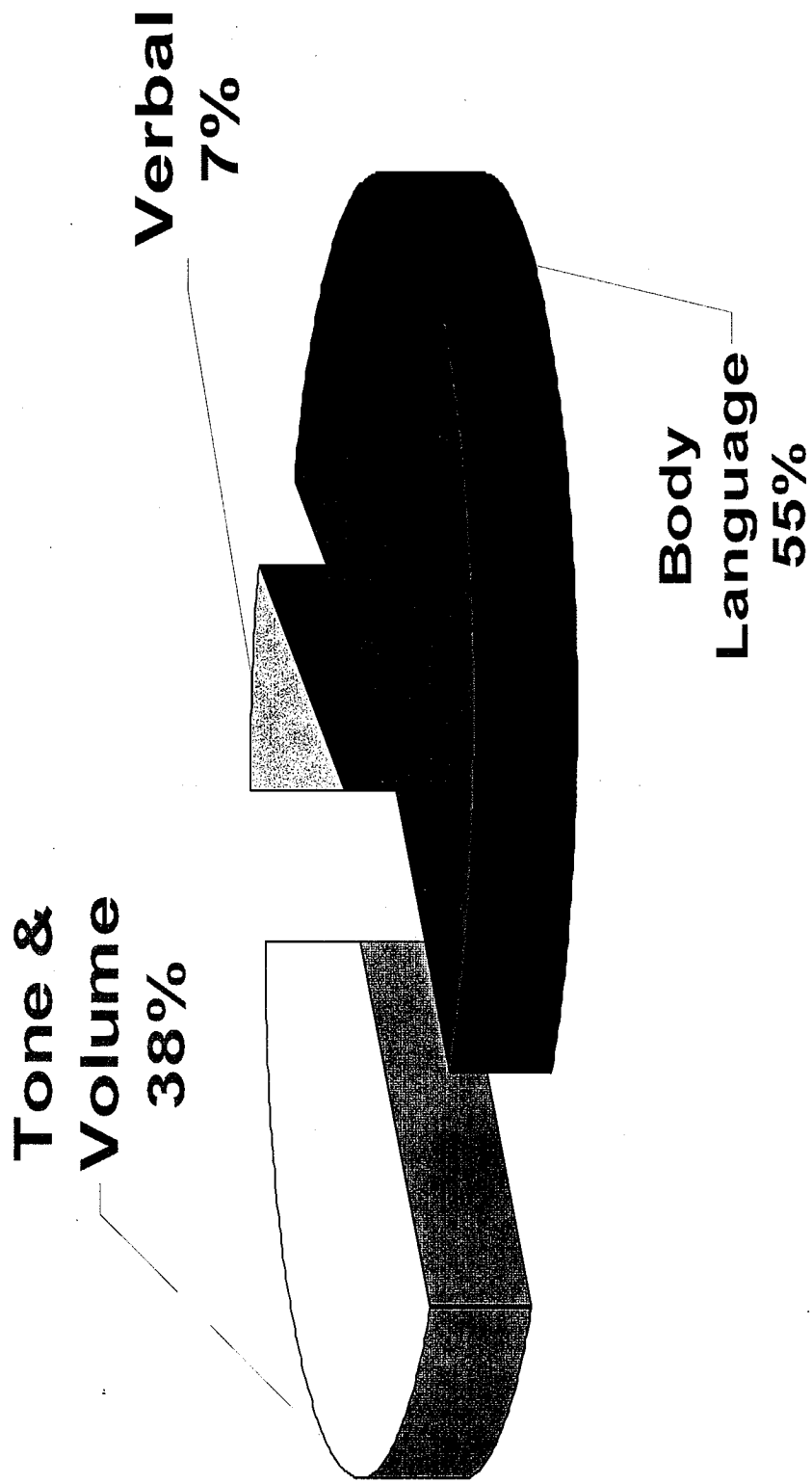


De-Escalation puts people in their comfort zones

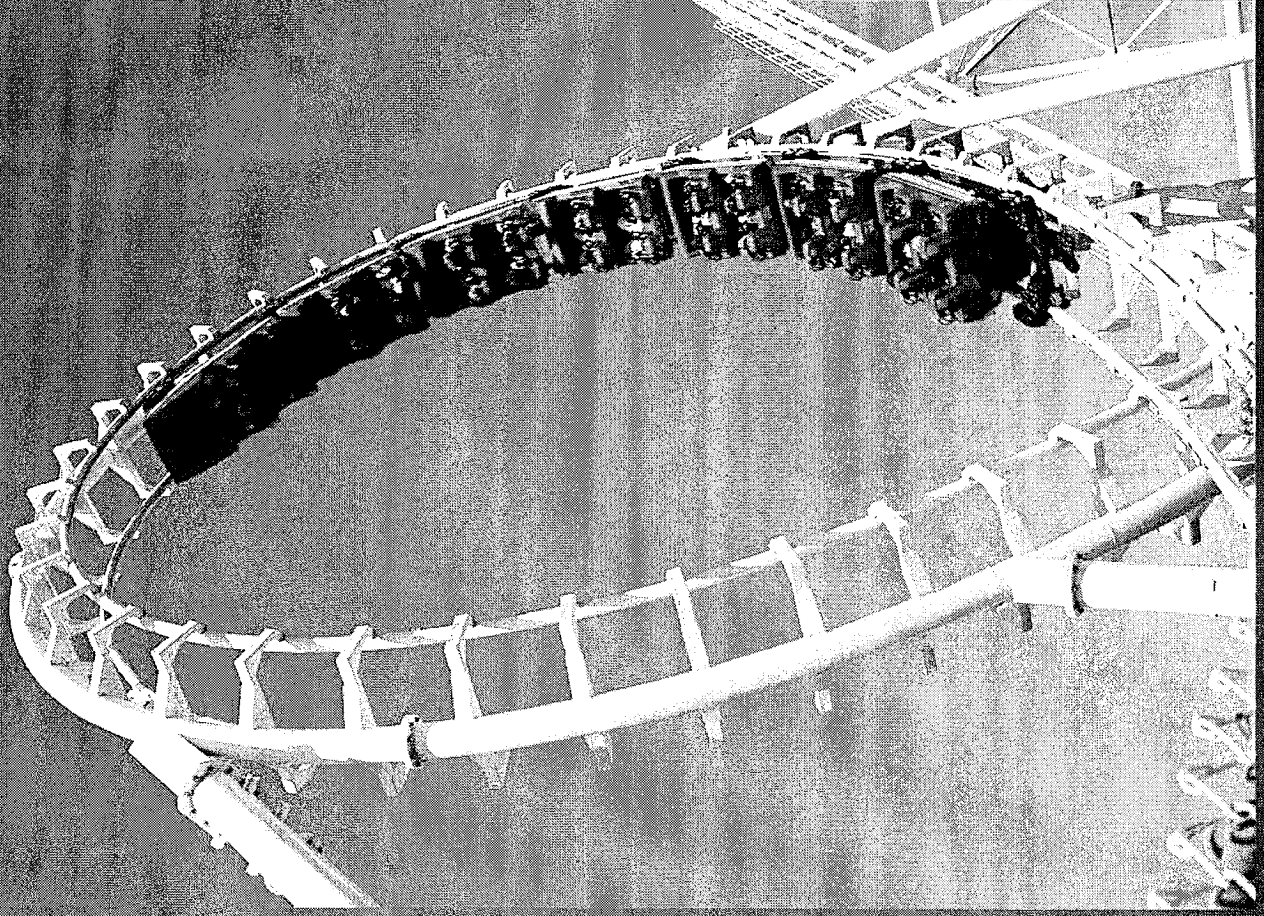


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Communication



**Communication
is a loop...
not a line**



You cannot NOT Communicate



Receiving a signal = Listening



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● ● Communication Recommendations

- Limit input
- Slow down
- Reduce distraction
- Use short sentences
- Simple language
- Repeat yourself
- Use silence

Receiving a message = Listening



Feb07-Dec08

Listening Skills

- Emotional labeling/ Acknowledge emotion
- Paraphrasing
- Reflecting
- Effective Pauses
- Minimal Encouragers
- Open-ended questions



AP Photo by Rick
Bowmer

Connect

Emotional labeling Effective Pauses

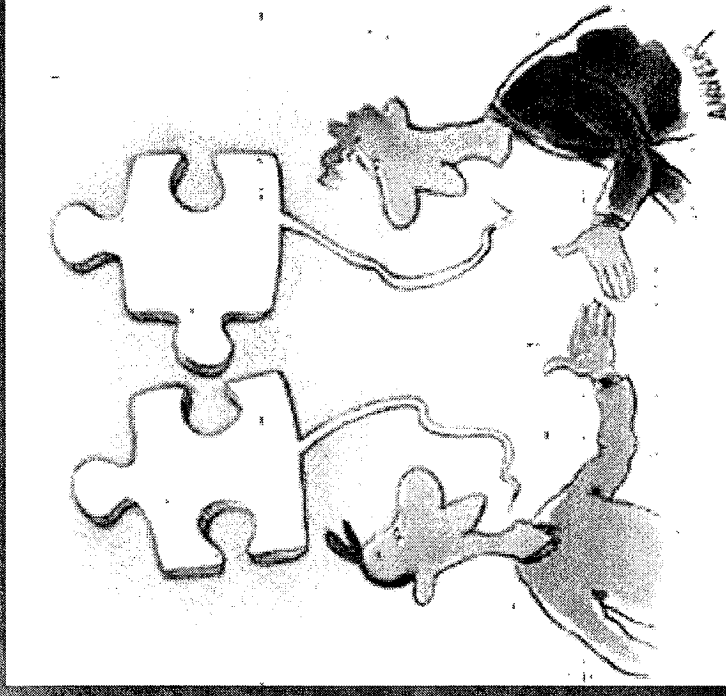
Paraphrasing

Minimal Encouragers

Reflecting

Open-ended questions

1. Are you telling me....?
2. Uh huh. Ok. Sure...
3. Did I get it right, that you...
4. What are your plans for today?
5. You seem frustrated
6. < > . I see.
7. How are you feeling?



● Connect

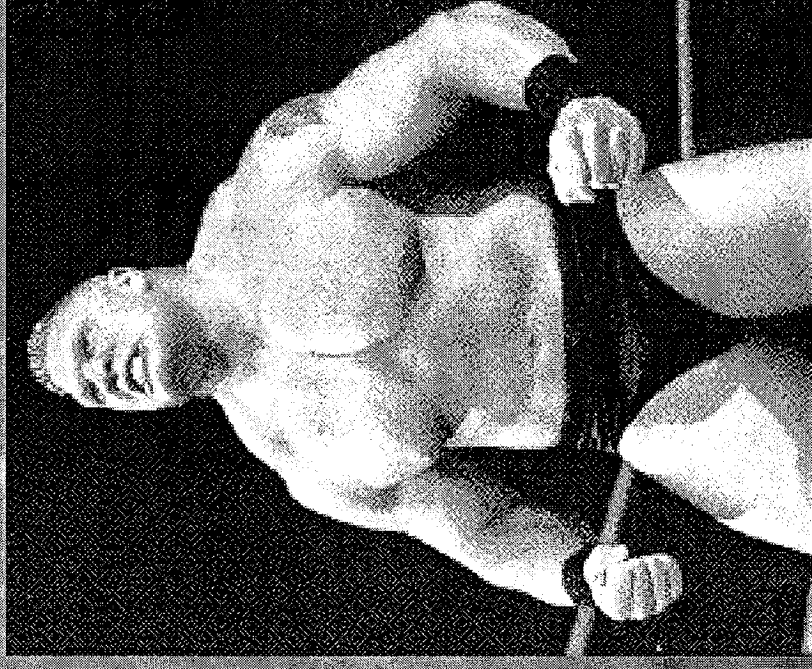
- I'm here to help you.
- What's going on today?
- Do you feel safe?
- What would help you feel safe(r)?



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Connect

- You seem... (name emotion)
- That must be...(name situation)
- It sounds like you...(restate concerns)
- So what you are saying is...
- How can we solve this problem today?



Connect

- I'd like to hear your side...
- Good for you for...
- You deserve that!
- That sucks!

● Communication ● Recommendations

- Are you hearing voices?
- What are they saying?
- Have they said this before?
- Have you ever acted on your voices?
- What helps?

Communication Recommendations

- Don't argue with their reality
- Listen for kernels of truth
- "I believe that you feel rays coming through the ceiling. That sounds terrifying."
- How will you defend yourself?
- How will you recognize the people who are out to get you?

Communication Recommendations

- Limit input
- Slow down
- Reduce distraction
- Use short sentences
- Simple language
- Repeat yourself
- Use silence

Risk Factors with Psychosis

May have an overlooked medical cause

May not care for basic needs

Disorganized behavior may place person in harm's way, e.g. walk into traffic

May not dress appropriately for weather

Catatonia may further complicate taking into custody

Risk Factors with Delusions

- Assess the dangerousness of the perceived threat; is it specific to a person?
- Increased risk if person has a plan for self-defense, retaliation, preemptive action
- Grandiose delusions can place subject, public or officer in harm's way
- Increased risk with substance abuse
- May cause person not to eat or drink or care for self.

Risk Factors with Hallucinations

- Assess if auditory hallucinations (voices) are giving commands
- Assess dangerousness of command
- Assess person's ability to cope with voices
- Visual hallucinations may direct a person toward harmful actions
- Distraction by hallucination may cause a person to be unaware of situation, placing at further risk

Risks with Medications used to treat Schizophrenia and Bipolar Illness

Tremors

Constipation

Dry Mouth

**Parkinson's like
signs**

Urinary Retention

Cardiac Changes

Weight Gain

Increased Cholesterol

Increased

Triglycerides

Diabetes

Diabetic

Complications

Blood problems

Breast Enlargement

Menstrual Irregularity

A life threatening syndrome

• High Fever

• Increased Blood Pressure

• Increased Heart Rate

• Muscle Rigidity

● Provocative

Spending Sprees

Excessive Energy

Euphoric

Decreased Need For Sleep

Rapid Speech

Racing Thoughts

Easily Irritated

Exaggerated Confidence/Grandiose

MANIA

● Reckless Driving

Hypersexual

Intrusive Behaviors

Denial Anything Wrong

Impaired Judgment

Change In Behavior

Substance Abuse

Risk Factors with Mania

- High risk for suicide
- Dehydration, malnutrition
- Reckless driving
- Financial losses
- Sexually transmitted disease
- Provocative behaviors may place in harm's way
- Grandiosity can increase risk taking
- Increased risk with substance abuse

Depression

- Persistent sadness or emptiness
- Too much/little sleep
- Early morning awakening
- Change in appetite
- Feelings of guilt, hopelessness, worthlessness
- Thoughts of suicide/death
- Loss of interest/motivation
- Irritable
- Trouble with concentration/Decision making
- Fatigue, loss of energy
- Anxiety
- Physical complaints

Risk Factors With Depression

- Suicide
- Recently starting meds
- Abruptly stopping meds
- Lethal OD with tricyclic meds
- Effects of anorexia, insomnia, immobility
- Lack of motivation/
productivity



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Suicide Risk Factors

- Older, white male
- Recent losses
- Alone, isolated
- Substance abuse
- Firearm in the home
- Childhood abuse
- Family hx of suicide
- Loss of physical health
- Resolve with religious belief



- Pain
- Employment problems
- Impulsivity
- Command hallucinations
- Hopelessness

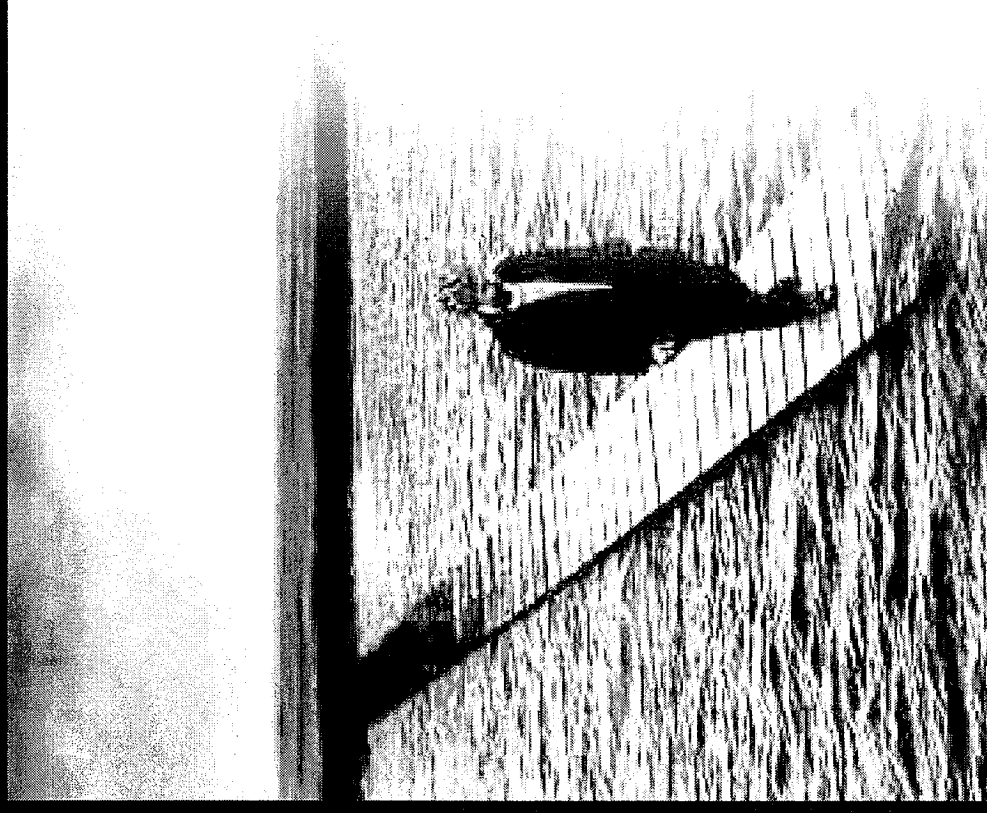
Suicide Risk Assessment

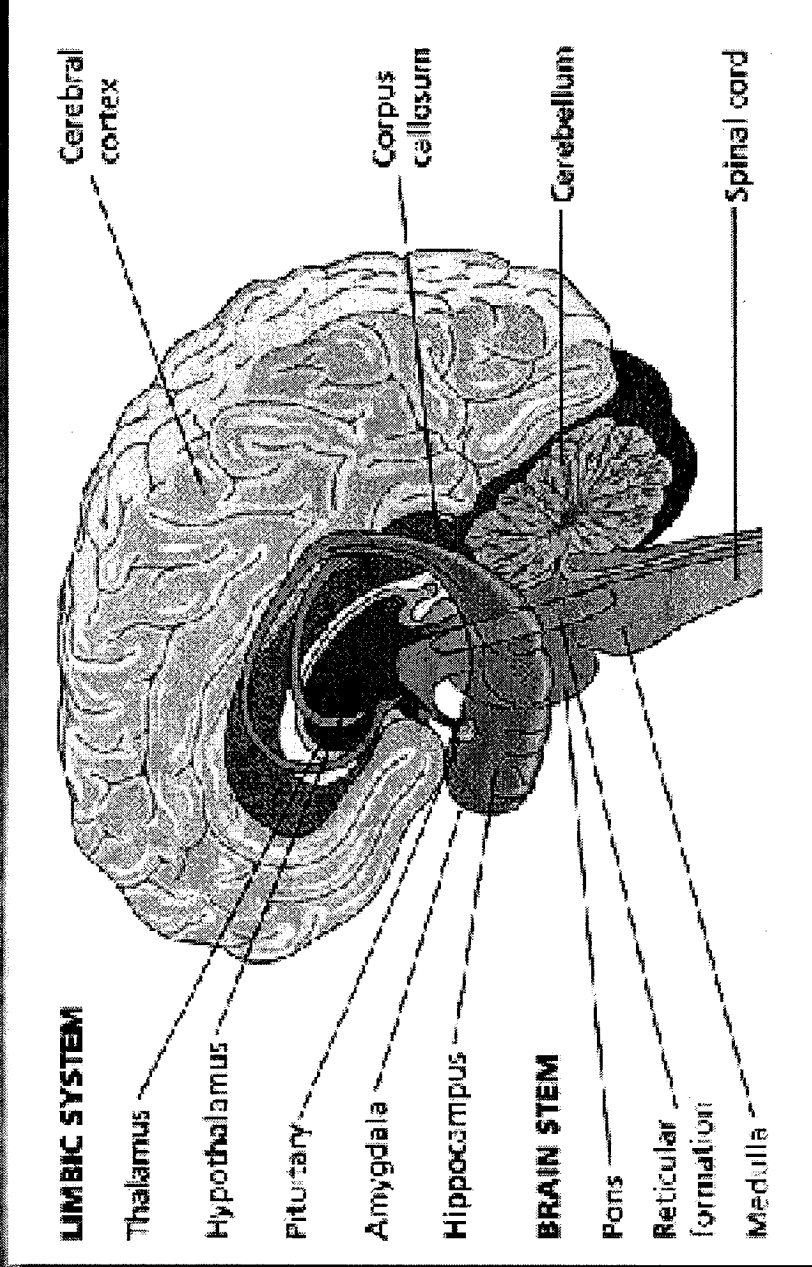
- Thinking about suicide?
- How much?
- Express intent to act?
- Prior attempts?
- How? How many times?
- Cultural concerns?
- Access to planned method?
- Lethality?



Suicide Risk Assessment

- Religious resolve?
- End life vs relief from pain?
- Social/family support?
- Professional help?
- Currently using drugs or alcohol?
- Medications?
- Future oriented?





Post Traumatic Stress Disorder: *Who is at Risk?*

- Persons who have experienced and/or witnessed:
 - Sexual assault/abuse
 - Physical/Emotional Trauma
 - Violent Crime
 - Natural Disasters

Post Traumatic Stress Disorder

Who is at Risk? (cont.)

- Immigrants who have fled from cultural persecution
- Experienced or witnessed combat
- Any event in which one could have been killed

Post Traumatic Stress Disorder (PTSD)

Signs/Symptoms

- Emotional numbness, distancing
- Irritability
- Flashbacks: maybe triggered by everyday events
- Nightmares
- Tendency to avoid reminders of event

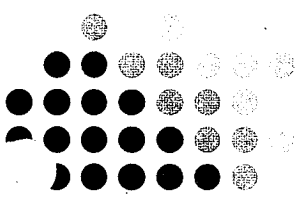
Post Traumatic Stress Disorder (PTSD)

Signs/Symptoms

- Startle easily
- Sleep disturbances
- Angry outbursts
- May be compounded by depression, substance abuse

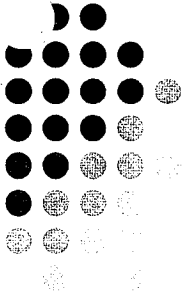
PTSD Chemistry

- ↓ Levels of cortisol (hormone which responds to stress)
- ↑ Level of Epinephrine and norepinephrine -- which causes hypervigilance



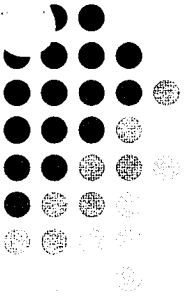
Mental Health Holds

- Police Officer Hold
- Director Hold
- Two Party Hold



ORS 426.228

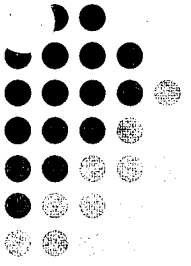
- **Custody; authority of peace officers and other persons; transporting to facility; reports; examination of person.** (1) A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness



Peace Officer Custody for an Allegedly Mentally Ill Person (Civil Custody Report) (850.20)

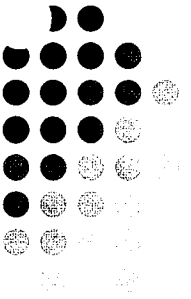
When taking an allegedly mentally ill person into custody (civil) for a mental health evaluation, members will:

- a. Transport the individual to the appropriate secure evaluation facility, or if there is no secure evaluation facility or if the unit is on divert, to the nearest designated hospital emergency department that conducts mental health evaluations.
- b. Remain at the facility until a physician determines whether the person will be admitted. If not admitted, the member may arrest the person for an offense, transport the person back to the original custody location or both. In the case where no arrest is made and the person chooses not to return to the location of custody, the person will be released outside the care facility.
- c. Complete an Investigation Report and a Civil Custody Report, before leaving the facility.
- d. Make copies of both reports. Leave the original Civil Custody Report and a copy of the Investigation Report with the secure evaluation unit or the receiving hospital. Turn in the original Investigation Report along with a copy of the Civil Custody Report to a supervisor before the end of his/her shift.



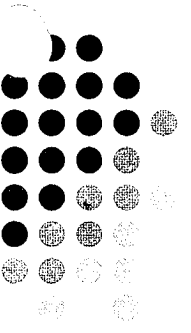
ORS 426.228

- The officer shall prepare a written report and deliver it to the treating physician. The report shall state:
 - (a) The reason for custody;
 - (b) The date, time and place the person was taken into custody; and
 - (c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.



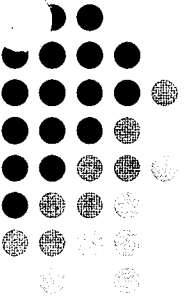
Police Hold

- 72 Hour Hold no longer exists
- Only medical condition that we can force people to get evaluated and possibly treated
- Most therapists, psychiatrics, psychologists, and counselors do not have the authority to place a hold on someone.



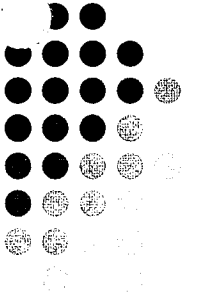
ORS 426.228 (Director's Hold)

- (2) A peace officer shall take a person into custody when the community mental health and developmental disabilities program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person. As directed by the community mental health and developmental disabilities program director, the peace officer shall remove the person to a hospital or nonhospital facility approved by the department. The community mental health and developmental disabilities program director shall prepare a written report that the peace officer shall deliver to the treating physician.



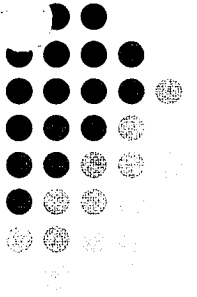
Emergency Department

- Not all hospitals take people on a mental health hold
- All hospitals in our area (save the old Woodland Park) take people on holds
- Hospitals need to be authorized/certified by the state to accept psychiatric patients



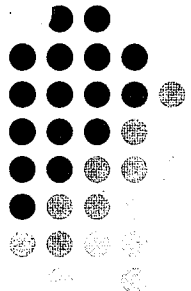
Emergency Department

- The mentally ill person will be evaluated by the emergency department doctor and/or a social worker.
- Hospital staff uses the same criteria that police do – imminent danger to self or others due to a mental illness.



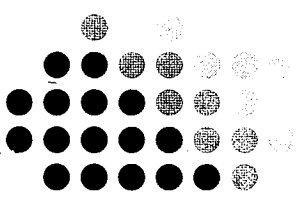
Emergency Department

- The hold can be dropped
- A Hospital Hold can be placed (essentially a continuation of the police officer hold)
- Once a Hospital Hold is placed, the hospital contacts County Mental Health and notifies the county investigator – the ICP. The ICP comes out every day, seven days a week, and evaluates the mentally ill person. They use the same criteria as everyone else.



County Mental Health Investigator

- The ICP can:
- Continue the hold
- Drop the hold
- Let the hold run out
- The ICP sets a hearing date for the mentally ill person within 5 business days
- The hearing can be set over for an additional week if the mentally ill person is participating in treatment.



Two Party Hold

- Two adults petition the court
- Unable to meet basic needs

Excited Delirium:

- State of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, euphoria, hostility, exceptional strength and endurance without fatigue.

Symptoms:

- Bizarre and violent behavior, most commonly violence towards glass
- Removal of clothing, public nudity (even in cold weather)
- Aggression
- Hyperactivity
- Paranoia

Symptoms:

- Hallucination
- Incoherent speech or shouting
- Grunting or animal like sounds
- Incredible strength or endurance
- Impervious to pain
- Hyperthermia / Profuse sweating (even in cold weather)

Excited Delirium

- Medical Emergency
- If you think it might be, call medical and get them en route
- There is disagreement in the medical community about what is actually happening physiologically.

IF POSSIBLE....

- Reduce time of struggle, it increases need for oxygen and increased heart rate
- Use Taser
- Hand over to medical as soon as possible
- Person needs medical intervention ASAP

Medical Transport Executive Order

PROCEDURE (630.45)

Transportation of Subjects

Members will not transport subjects who appear to be seriously injured, seriously ill, or unconscious unless an on-scene evaluation by EMS determines the subject is cleared for officer transport. This includes, but is not limited to any subject who:

a. Appears to be suffering from excited delirium.

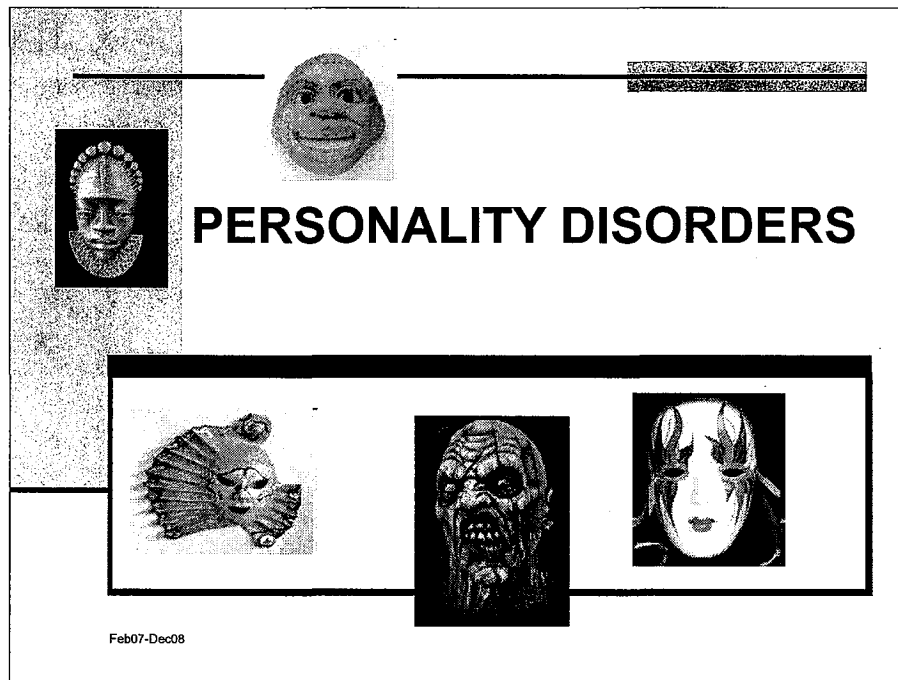
Symptoms may appear as severe agitation, over stimulated or wired appearance, paranoia, disorientation, extreme restlessness, involuntary twitching of small muscles and hallucinations.

Medical Transport Executive Order

- b. Suffers any seizure prior to (per witness statements or self-proclamation) or during police contact.
- c. Displays respiratory difficulty, including but not limited to, shortness of breath, extreme wheezing, etc.
- d. Displays obvious signs of head trauma or loss of consciousness prior to (per witness statements or self-proclamation) or during police contact.
- **e. Appears to be extremely intoxicated and/or under the influence of drugs in conjunction with any of the above symptoms and has been involved in a prolonged physical altercation.**

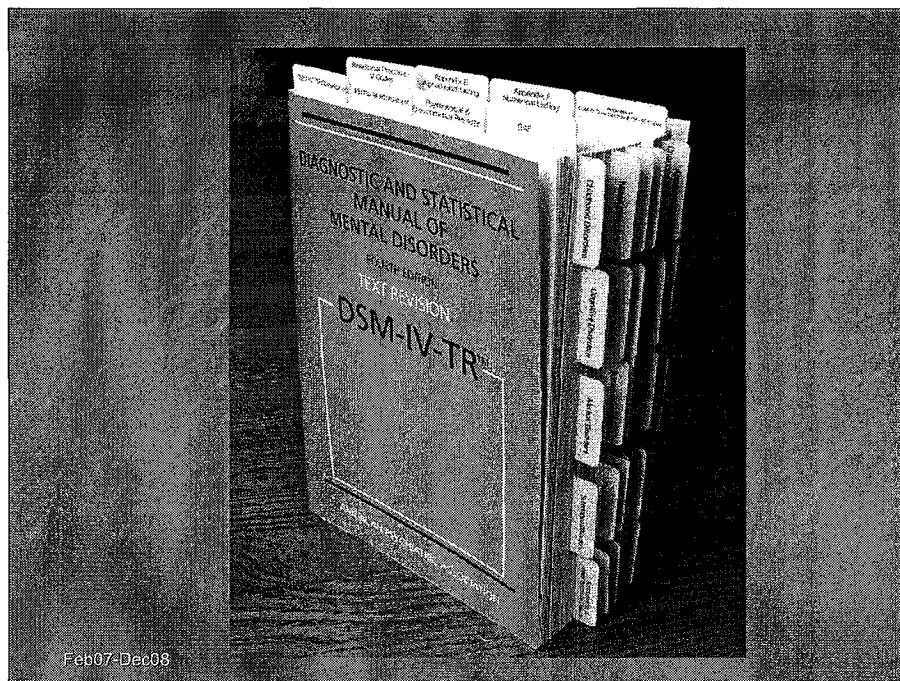
Medical Transport Executive Order

- **Regardless of Location or Situation (630.45)**
- Members will immediately call EMS if they have any concerns or questions regarding a subject's medical status during an incident or custody situation. EMS will respond and evaluate and assess the subject's medical condition.
- Once on-scene, EMS will have the responsibility of determining the appropriate medical treatment and mode of transport for the subject.
- If members transport a subject to jail, EMS will provide the transporting member(s) with a copy of the pre-hospital medical treatment worksheet.



What is a personality? Think about your own personality? How would you describe yourself? Are you one thing? No, you have different personality traits. What kind of traits do you look for in a friend? What are some personality traits that you don't gravitate towards? Before we go into the different personality disorders, let me explain how they fit into the grander scheme of mental health. All week, Kay has been talking about mental illnesses. Schizophrenia etc are MI. PD are NOT mental illnesses, though the person can look very dysfunctional. This is impt. Because often when people don't get held in the hospital, it is because they have a personality disorder and not a mental illness.

PDs-don't respond to meds



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DSM-IV Five Axis System

- Axis I: Clinical Disorders (mental health)
- Axis II: Personality Disorders & MR/DD
- Axis III: General Medical Conditions
- Axis IV: Psychosocial/ Environmental Problems
- Axis V: Global Assessment of Functioning 0-100

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A person can have an Axis I AND an Axis II diagnosis. (Show the DSM-IV and its divisions). In addition, people can have more than one personality disorders. (Not to be confused with multiple personalities). In the big book they "cluster" the personality disorders, depending on the type of traits people with these disorders exhibit. There are 10 different personality disorders. For the purposes of this class, we will only cover 4. We're going to look at the ones with the highest correlation with criminal bx.

Multiple Diagnosis

You can have:

- Mood disorder (ie. Depression) AND
- Psychotic disorder (ie. Schizophrenia) AND
- Personality disorder (Antisocial) AND
- Substance dependence (eg. Meth)

*The more diagnoses, the worse the prognosis
and the more bizarre the behavior*

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Can you have a personality disorder and a mental illness? Can you have schizophrenia and be antisocial and an alcoholic?

Personality changes may also occur as a result of a medical condition: head trauma, stroke, cerebral tumors, epilepsy, AIDS

Four personality disorders you might encounter in your work:



Borderline

Histrionic

Narcissistic

Antisocial



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These are the ones we are going to talk about today, in addition to some subcategories.

What is a personality disorder?

- Onset in adolescence/ early adulthood
- Pervasive, Rigid and Inflexible
 - Work, School, Relationships
- Unchanging over time
- Leads to distress or impairment

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Onset-you don't dx a personality d/o for the first time when someone is 55 or when someone is a two. Why not? Still developing. Personality is forming. Pervasive means it shows up in different areas of your life. Might be jerk at home but have good relationships at work or in the locker room. Rigid- can't adapt to changing situations. For most of us, say we had been planning to go out to dinner with a friend and that friend calls and needs to cancel at the last minute. We might be momentarily disappointed but then we move on. We don't have a major meltdown because of it. A person who is borderline won't suddenly become mature when the situation demands it. They take their disorder with them like a backpack that you can't take off. Goes where you go. Affects your ability to function in all areas of your life-at home, at work, at the bar, on the playing field.

Balance of attachment: between enmeshment (BPD) and detachment (psychopathic)

Personality Disorders

The development of a personality disorder is a combination of genetics, culture, and environment.

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Personality Disorders In General:

- **Increases the risk for violence**
- Show a lack of ability for insight
- Generally blame others for their problems
- Have trouble self-correcting
- Have poor interpersonal relationships
- Trouble functioning at/maintaining work
- Require long-term treatment
- Low frustration tolerance
- **Some PD's are highly correlated with certain crimes**

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Makes sense re: crime when you look at the list above.

Insight: not the same as the lack of insight with schizo etc. Don't think committing a crime is a bad thing. Don't take responsibility. "victim" of their circumstances.

Trouble self-correcting. Get into a jam, go to jail, but have a hard time doing something different when he/she gets out of jail.

Poor interpersonal relationships-when all you care about is getting your own needs met, makes it hard to have a relationship which involves thinking and feeling outside of yourself, at times. When we are two, that is appropriate, when we are 22, not appropriate.

Low frustration tolerance-again, like the two-year old.

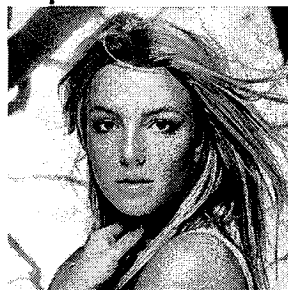
Treatment for PD: meds for the anxiety, depression-SSRI;s also anticonvulsants can reduce impulsive, angry outbursts. Does not affect the traits themselves.

Borderline Personality Disorder

Key word: Needy

Must have at least four:

- Frantic efforts to avoid real or imagined abandonment
- Unstable self image or identity
- Unstable, overly intense relationships
 - “Angel or Devil”
- Impulsivity in sex, binge eating, & spending
- Manipulation
- Emotional instability
- Jealousy
- Recurrent suicidal gestures



Britney Spears

Feb07-Dec08

Identity diffusion- low self-esteem. Not a well-developed sense of themselves.

DBT-learn coping skills. Frantic efforts to avoid real or imagined abandonment. Can result in fear/anger when, for example, there are unavoidable changes in plans-clinician announcing end of session, panic/fury when someone must cancel or reschedule an appt. Abandonment means they are “bad.” Angel vs. devil. Impulsivity in eating, gambling, sex, driving recklessly. Frequent SI. (But 8-10% do complete suicides) and self-mutilation.

Low self-esteem.

Self-Mutilating Behaviors

- Interfering with the healing of wounds
- Hitting self
- Hitting objects
- Burning
- Cutting or scratching



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What kinds of self-mutilating behaviors have you seen?

Cutting kits. Ritualistic.

Why would someone self-mutilate? (next slide)

Reasons for Self-Mutilation:

- To relieve numbness
- To release pent up emotion
- To feel less detached
- To provide a sense of control
- To punish oneself for feeling worthless
- To get a reaction for feeling ignored and misunderstood
- To non-verbally express themselves



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Histrionic

Key word: dramatic

- Constantly seeking attention
- Egotistic
- Overly concerned with how others perceive them
- Excessive emotional displays
- Over reacts to minor stress



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Like your teenager?

Narcissistic

Key word= grandiose

■ Must have five of the nine:

- Grandiose sense of self-importance
- Interpersonally exploitive, predatory
- Believes he is special
- Preoccupied with fantasies of success, power, brilliance
- Lacks empathy
- Requires excessive admiration
- Envious
- Arrogant
- Hypersensitive to the opinion of others

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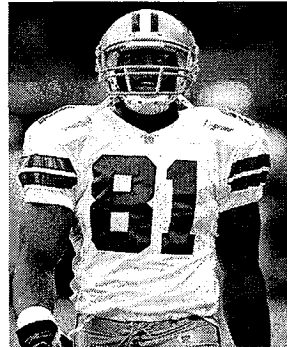


Greek myth: Narcissus- Fell in love with his own reflection and spent his days staring into a reflecting pool.

Enron Execs: CFO Fastow

Narcissistic

- **Main trait:** Grandiosity
- **View of the world:** Theirs
- **View of themselves:** Special
- **View of others:** Their servants
- **Deal with the world by:** Image management
- **E.G.** Most world leaders, sports figures



Terrell Owens

Feb07-Dec08

Approach to NPD: emphasize their uniqueness and get them to brag, support their special qualities, and give them the rope (they like to talk). Crimes are exploitive. Cannot view the impact they have on others.

Antisocial Personality Disorder

Key word= callous

■ ***Must have at least three:***

- Failure to conform to laws or social norms
- Deceitfulness
- Impulsivity
- Reckless disregard for safety of others
- Lack of remorse
- Irresponsibility
- Juvenile delinquency



*used to be called "sociopath"

Life is unfair. Losers deserve to lose. He had it coming anyway. She shouldn't have worn that see-through blouse.

Antisocial Personality Disorder

- **Main trait:** Exploitation
- **View of world:** Dog eat Dog
- **View of self:** Superior
- **View of others:** Suckers
- **Deal with world:** Opportunism



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The Antisocial Lifestyle

Self-regulation problems

Histories of violent crimes

Non-violent crimes

Substance use

Poor employment record

Irresponsibility in finances/home

**Poor response to probation/parole
conditions**



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Criminals. Most of the people in jail have this.

Psychopaths

- Two views of the psychopath:

- **Cold-blooded predator**
- **Impulsive, charming thug**

- High risk for violence over life span
- 3-4x more likely to reoffend following release



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Blurred distinction between psychopaths and antisocial personality disorder. It is confusing for clinicians and according to one of the most renowned experts on Psychopaths (Robert Hare), also in the DSM-IV.

Examples: John Wayne Gacy-murdered at least 33 young men and buried most of them in crawl space beneath his house.

Ted Bundy: murdered more than two dozen young women in the 70's, going into several states to claim victims

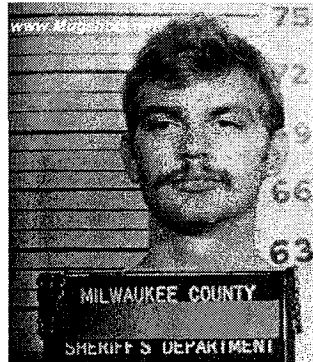
Green River Killer? Dexter?

Violence is more predatory, motivated by identifiable goals, carried out in a calculated manner without an emotional context. Don't tend to commit crimes of passion, such as during DV or extreme arousal.

"madness without delirium", "moral insanity"

Psychopaths

Combination of narcissistic +antisocial:



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Jeffrey Dahmer

Psychopaths score high on factor 1 AND factor 2. Antisocial score high on factor 2 only (impulsivity, stimulation seeking, irresponsibility). Studies found that "group therapy" made things worse for psychopaths. Just learned how to manipulate.

Can be CEO's, politicians, entrepreneurs. Embezzle retirement funds, immoral officials.

Hare study: countdown timer. At zero "harmless but painful" shock with electrode taped to finger to measure perspiration. Normal people start sweating. Psychopaths didn't sweat. Didn't fear punishment. Quote of psychopathic rapist "They are frightened, right? But, you see, I don't really understand it. I've been frightened myself and it wasn't unpleasant."

Hare study: groups of letters flashed to volunteers. Nonsense and real words. Press a button when they recognized a real word. Hare recorded response time and brain activity. Normal respond faster & display more brain activity when processing emotionally laden words such as "rape" "cancer" than "tree". No difference with psychos. Emotional language is a second language.

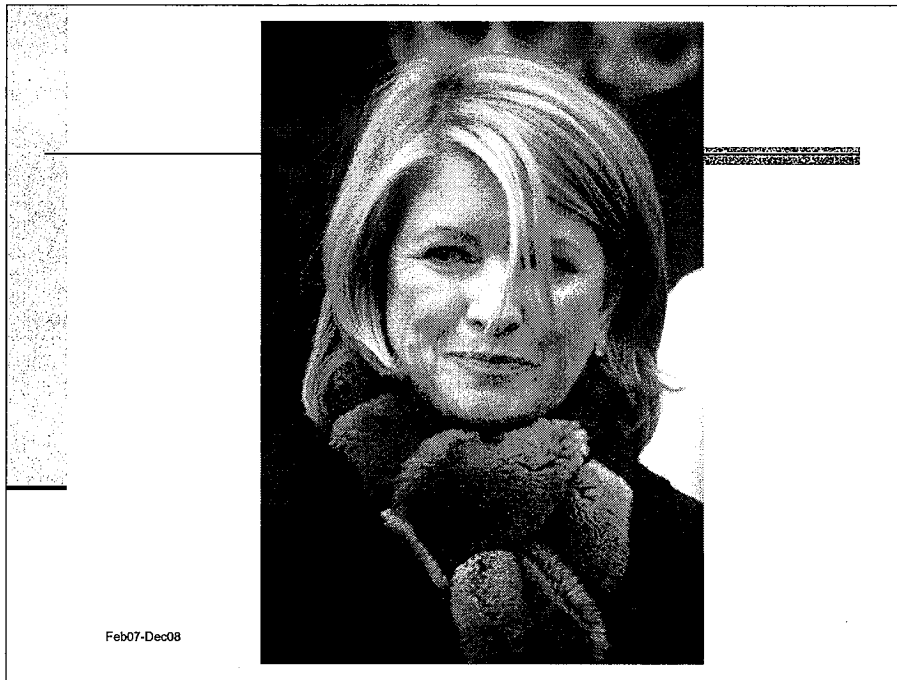
Strategies: think of how much better you will feel/think of the families left behind. But if no guilt or sorrow...appeal to his grandiosity.

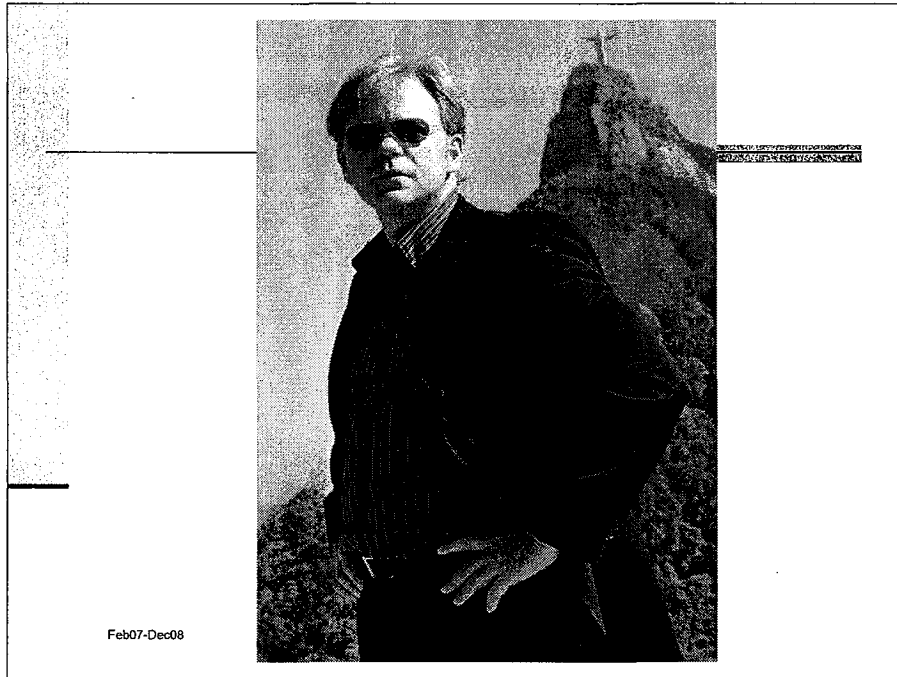
Psychopathology

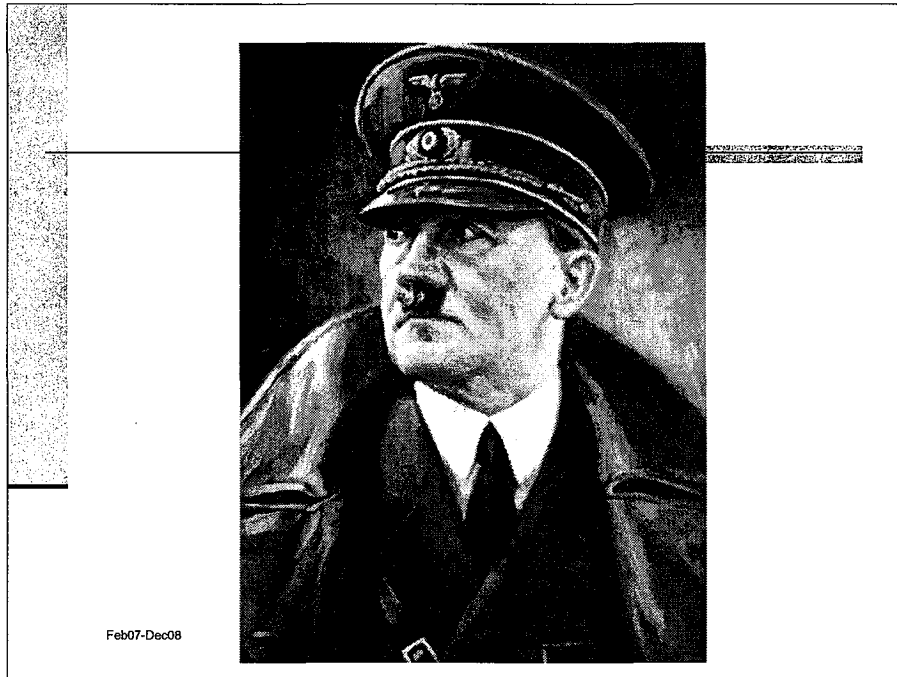
- Narcissistic + antisocial traits
- Lack of remorse
- Superficial charm
- Manipulation
- Shallow emotions
- Irresponsibility
- Uses people as objects
- Grandiosity
- More likely to pose serious threat

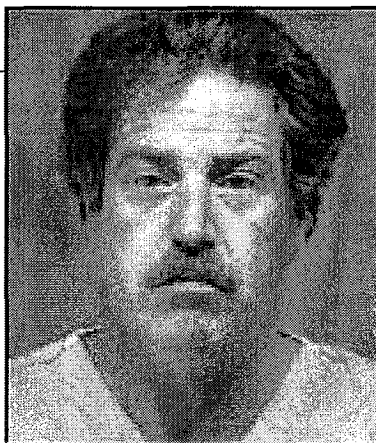


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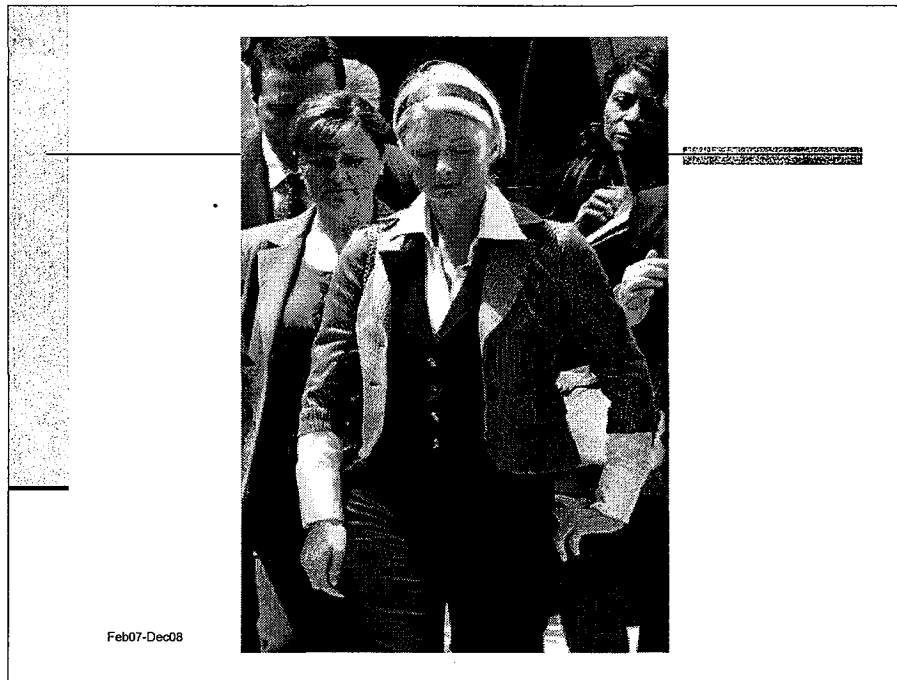


Ward Weaver

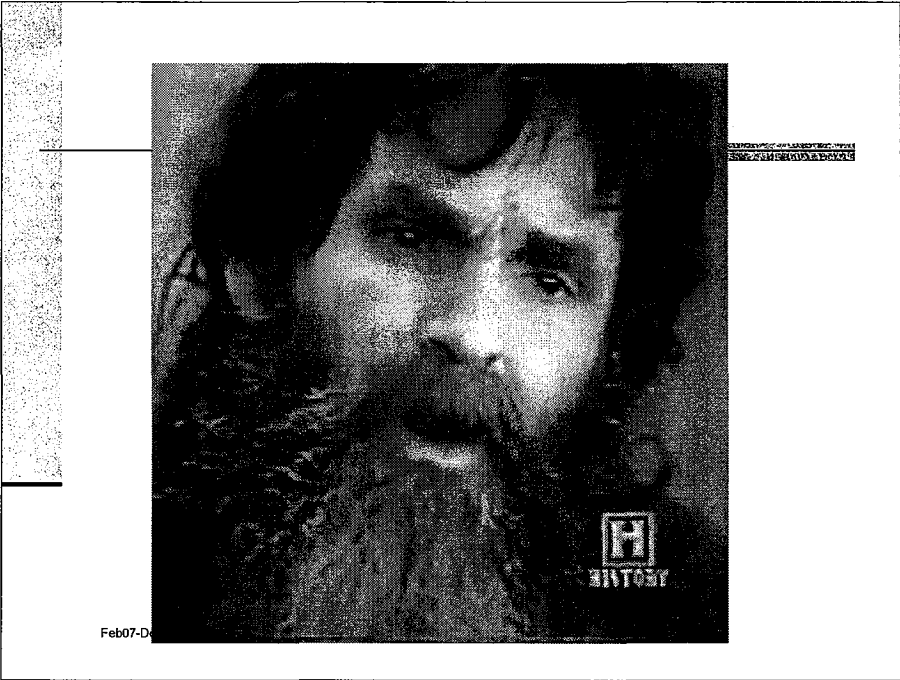
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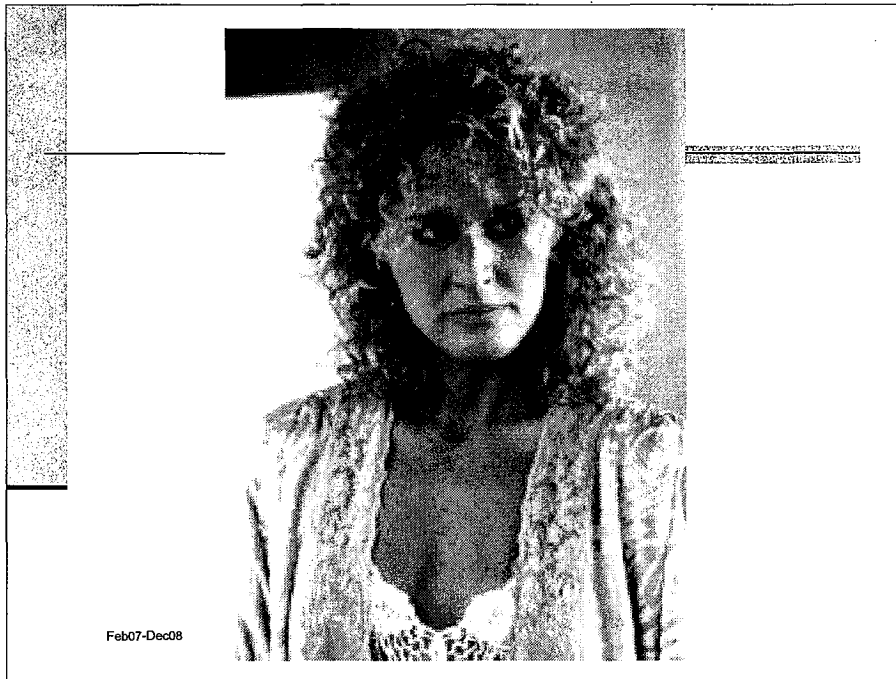


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Paris Hilton





END

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Where can you get this info?

- Psych reports, review of criminal history and crimes (motivations: predatory, fun, sadistic, reactive)
- YOU keep seeing them over and over

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Highest correlation with criminal
behavior

Cluster B:



Antisocial

Narcissistic

Borderline

Histrionic



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Cluster A: mature or odd (schizoid, etc) Cluster C: anxious and fearful

Borderline (=needy)

- Poor anger control
- *Self-mutilation*
- Intolerant of isolation
- Manipulation for personal gain
- Overly dependent
- Unstable self image or identity
- Impulsive
- Stormy interpersonal relationships
- Mood fluctuations
- Intolerant of abandonment
- *Suicidal threats*

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DBT-learn coping skills. Frantic efforts to avoid real or imagined abandonment. Can result in fear/anger when, for example, there are unavoidable changes in plans-clinician announcing end of session, panic/fury when someone must cancel or reschedule an appt. Abandonment means they are "bad." Angel vs. devil. Impulsivity in eating, gambling, sex, driving recklessly.

Self-Mutilating Behaviors

- Interfering with the healing of wounds
- Hitting self
- Hitting objects
- Burning
- Cutting or scratching

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Reasons for Self-Mutilation:

- To relieve numbness
- To release pent up emotion
- To feel less detached
- To provide a sense of control
- To punish oneself for feeling worthless
- To get a reaction for feeling ignored and misunderstood
- To non-verbally express themselves

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Narcissistic (=grandiose)

- Expects favorable attention from others
- Hypersensitive to the opinion of others
- Masks anger/shame with aloofness
- Fragile self esteem
- Reacts to criticism with extreme humility
- Exaggerated self importance
- Lack of empathy

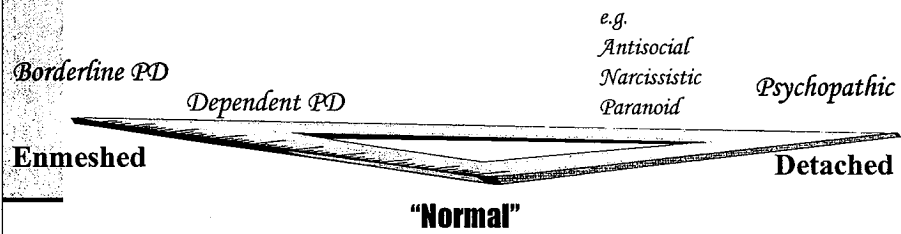
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Borderline

- Poor anger control
- Self mutilation
- Intolerant of isolation
- Manipulation for personal gain
- Overly dependent
- Unstable self image or identity
- Impulsive
- Stormy interpersonal relationships
- Mood fluctuations
- Intolerant of abandonment

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Attachment: "Normal" & Pathological



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Why attachment matters...

- Degree of attachment tells you:
 - What to expect from the person
 - What risk they pose to you as an officer
 - How to approach the person
 - How to verbally disarm the person
 - How to interact when interviewing/interrogating

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Signs of detachment=Taking

- Exploitation of others (pimping, stealing etc)
- Lack of negative emotions when separating
- Multiple & severe violent acts in love relationships
- Lack of remorse/guilt for harmful behavior
- Cannot describe social emotions (love)

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Signs of over-attachment= Taken care of

- Crisis when separating from person they “care” about (“can’t live without them”)
- Overly intense relationships
- Fear of abandonment and pathological jealousy
- Use of power and control tactics in an effort to keep the person

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Antisocial (=callous)

- Aggressive
- Disregard for others safety
- Lack of remorse
- Can be charming
- Does not conform to social norms, rules, or laws
- Manipulative
- Disregard for others safety

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Psychopathy = Two Personality Disorders

■ NARCISSISM

- Superficial Charm
- Grandiosity
- Pathological Lying
- Manipulation
- Shallow emotions
- Lack of Guilt
- Callous/Lack of Remorse

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■ ANTISOCIAL

- Need for Stimulation
- Criminal Versatility
- Irresponsibility
- Poor Behavioral Controls
- Failure to Accept Responsibility
- Juvenile Delinquency
- Parole Violations
- Lack of Plans

Borderline Personality Disorder (=needy)

- **Main trait:** Unstable, intense relationships, drama and CRISIS
- **View of world:** rejecting
- **View of themselves:** Vulnerable, abandoned
- **View of others:** Angels or Devils
- **Deal with world by:** Emotional justification

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View of the world: we all have a view of how the world works. It is a nice world out there or a mean world? Does the world work for you or against you?

View of themselves: "Vulnerable/abandoned (victim-no taking responsibility for their actions)

Angels or Devils- "splitting" This is a time when PR will not be naïve and compassionate.

Deal with the world by: Emotional justification. It's ok that I get angry with my counselor because she was late.

Histrionic (=dramatic)

- **Main trait:** Over-expressiveness
- **View of world:** Impressionistic
- **View of self:** Charming, center of attention
- **View of others:** Admirers
- **Deal with world by:** Performing
- **e.g. Scarlett O'Hara from "Gone with the Wind"**



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View of self=charming, center of attention; View of others=charming; Deal with world by performing

Impressionistic: Monet (garden), based on subjective reactions presented unsystematically. His view of world is as he sees it. Inner drama. There is no system in it. Chaotic. No cohesiveness.

Shaping Personality: Developmental tasks

Boundaries
Flexibility
Emotional states
Empathy
Appropriate behaviors
Accountability



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Let's talk about how our personality develops. Many different theories. They are just that, theories. Genetics, culture and environment. Let's talk about the developmental tasks. As we mature we need to learn about boundaries. A baby needs to figure out where it begins and ends. When you are born, you think you are an extension of your mother or primary caretaker. Your mother is not you. She can leave and come back. You are different people. Everyone has a bubble, a boundary to their identity. I am me. You are you. When a child is molested, their boundaries are transgressed. Someone has come into their bubble without permission. Flexibility- we have to learn to adapt to a changing environment. Mom and dad come and go. The environment is not static. (As good as it gets- Jack Nicholson needs to have silverware a certain way). We have to learn to cope with different emotional states. Tolerate being hungry or thirsty or hot or cold. Empathy- care for others. When you are two, it is all about you. Parallel play. Don't relate. What happens to a person who doesn't develop empathy? Appropriate behavior- throw ball in yard not house. Learn rules so later you don't drive drunk etc. How to handle being alone? Can you be alone without being lonely? Become very dependent on others if we can't be alone. OK-development of self-esteem. Always criticized? (not to get too Freudian) OR always praised- false sense of self. Accountability- Every action has a reaction. Pick up your toys after you play with them. Take responsibility for your actions. Cause and effect. -

PSYCHIATRIC SECURITY REVIEW BOARD

(PSRB)

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Structure of Adult Board:

- 5 member part-time multi-disciplinary
 - psychiatrist
 - psychologist
 - attorney experienced in criminal practice
 - parole/probation officer
 - member of the general public

Psychiatric Security Review Board (PSRB)

- Guilty Except for Insanity
- Sentenced to maximum sentence for crime committed
- Their mental status is reviewed every two years (up to every 6 months upon appeal)

Early Discharge

- A person no longer has a mental disease or defect. (If the disease is in remission but occasionally becomes active, the board will still consider the person to have a mental disease or defect.)
- The mental disease or defect continues but the person no longer presents a danger to others.

Where are they?

- State Hospital Forensics Ward
- Currently 745 people currently under PSRB jurisdiction
- 368 are at the State Hospital
- 377 are on conditional release in community facilities

Community Facilities

- Secured Residential Treatment (10.5%)
- Residential Treatment Facility (15%)
- Residential Treatment Home (15%)
- Adult Foster Home (16.5%)
- Semi-Independent/Supported Housing (13.5%)
- Intensive Care Management (3%)
- Independent Living (25.5%)
- Other (1%)

PSRB

- PSRB recidivism rate: 2.2%
- Dept of Corrections recidivism rate: 31.4%
- Small case load for case managers
- Quick to respond and hold people accountable
- PSRB “hit” in LEDS is like a warrant.
Person would be transported directly to
State Hospital (Salem)

PSRB EPR HIT

UP00000000. Aug 08, 2008 14:03:54

BVP DR0340100 20080808 14:01:06 (LEDS)

OR PSYCHIATRIC RV BD

(PRB9)

*NOTIFICATION OF POSSIBLE OFFENDER CONTACT**

QW.DR0340100.NAM/ *Last, First*

.DOB/04161960

ORI IS/BEAVERTON POLICE DEPARTMENT

(W494)

** POSSIBLE MATCH RETURNED **

EPR DR026035C NAM/ *Name*

1960/07/10 F W 506 160 BRO BRO LNU/W02452 RTP/PCR

MIS/---NOTIFY PRB OF ALL INQUIRIES BY AM MSG---OR CALL LOCAL MENTAL HEALTH

WORKER PATTY

AT 503-

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LEDS REVOCATION ORDER

QLW.LNU/W0S4535086

#####

LPP0GG40000. Aug 27~

2008 12:46:01

REUR 0664 LEOS

QLW.OR02G035C.LNU/W0S45350B6

NO CRIMINAL WARRANT

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO
OREGON STATE HOSPITAL. AUTHORITY DRS 1G1.330 ~5)

(BASED ON LNU)

EIP OR02S035C NAMI DOBI

SEX/M RAC/W POB/OR HOT/50? WGT.' 135 EYE/ORN HAI!RED SKNI

OCA/03-1S02 SMT/Se R HND FPC/20070305131052081610

FBI! SIDI SOC!

MNU!

RECORD INFORMATION

DOR/2008/06/23 RTP/PRE

MIS/HIT CONFIRMATION CALL 503-945-2800--TAKE TO OREGON

CENTER ST NE, SALEM-ORIGINAL CHARGE ASSAULT r

STATE HOSPITAL 2600

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ORS 161.336 (6)

- The community mental health director, any peace officer...make take a person on conditional release into custody or request that the person be taken into custody, if there is reasonable cause to believe a person is a substantial danger to self/others because of mental disease/defect and is in need of immediate care/custody treatment.

Common Conditions of Release

- Mandatory Mental Health Treatment/Supervision
- Case manager who reports to PSRB about person's status & violations
- Housing Arrangement
- NO drugs/alcohol
- Random drug/alcohol testing
- No firearms
- No driving

- Jesus believes in you
- Sinner
- Satan will try to get to you but don't fall to his tricks
- I am God and I will set you free
- People will not believe in you
- You come to my kingdom as a God
- You must be cleansed

- You will go go heaven if you kill yourself
- You will overcome if you suffer
- Medications will not cleanse your soul
- Jesus believes in you
- Those who want to help will kill you
- You will suffer
- People will persecute you
- You will suffer

- You're a bad person
- Everybody hates you
- You should not be allowed to live
- Nobody cares about you
- You should die
- Liar! Liar! Liar!
- You never do anything right
- What makes you think you should go on with your life

- This shows what a jerk you are
- You should die
- You have no real friends
- You are self centered and selfish
- You always fail
- Nothing you do is important
- You're lazy
- You're a worthless person
- Nobody cares

CIT SCENARIO #2: 16 year old suicidal subject at parent's home

Dispatch

- Officer dispatched to 1234 Cherry Lane
- Officer runs address
- No flags, arrests, wants or other info in PPDS

Summary

Role-Players

16 year old female

Mother

Father

Fact Situation

Profile Role-player: 16 year old girl

You are a typical "16 year old" and you also suffer from bouts of depression. You have been seeing a psychiatrist for the past year. You started seeing her after a friend committed suicide. You are on Prozac but think that "most teenagers are depressed." You have considered suicide in the past, the most recent being last month when you got a hold of your mother's benzos. You think your mother and father (especially mother) is "stupid" and doesn't understand what it means to be a teenager.

Profile Role-player: Mother

You are worried about your daughter and feel you don't have much control over her anymore. You are at odds with her father, who you think is too lax. You are taking anti-anxiety medication. You missed your last dose. Police have the perception that your lack of firm parenting has created this situation.

Profile Role-Player: Father

You try to support the mother but also feel that she is too controlling and should give the daughter more space. You believe she'll "grow out of it" and do not really believe in diagnosing teenagers. You reluctantly admit that perhaps it would be a good idea for your daughter to go to the hospital tonight.

Dynamics

Mother calls police because her daughter grabs a knife after an argument. As mom is calling police, the daughter dumps the knife in the kitchen sink. Mom tells police daughter no longer has the knife *when police ask about it (do not volunteer this info)*. Mom tells police as they walk in that her daughter needs to go to the hospital. "Her

psychiatrist told us that when she gets like this again, she should go to the hospital. We don't want to take her in our car because we are afraid she might jump out." Mom goes downstairs (or where ever the daughter's room is in the scenario) but escalates daughter. Police need to separate the parents from the daughter and interview each of them separately. Daughter wants to tell police what jerk her mom is and how she feels like she is "in jail." Father and mother are not on the same page. Daughter admits (after first venting about her ex-boyfriend and her best friend and the stresses of high school) that she has thought about suicide ("doesn't everyone?") as recently as one month ago (by means of mother's benzodiazepines) but has no intention of hurting herself tonight.

Objectives

- Determine location of daughter immediately after entering residence to determine she is safe
- Explain to parents that police are not obligated to take her, despite the psychiatrist's suggestion
- Separate the parents and the teenager
- Consider that father has the most "objectivity" and focus efforts on him
- Explain hold criteria to parents and teenager
- Suicide assessment on daughter (Caution: do not assume that just because the family dynamics are messed up daughter is not legitimately suicidal)
- If hold is placed, explain procedure re: handcuffs; parents need to sign daughter into hospital
- If no hold placed, make a safety plan with parents. Consider returning to home the following day to check.
- Consider f/u phone call to Project Respond for engagement with family to secure resources

Logistics

Need CIT evaluator AND patrol tactics evaluator.

Location

Props

Scenario #2: CIT: Depressed Woman in House

Dispatch

- Officer is dispatched to woman's home-10 Code?
- Dispatch received call from woman's sister in Texas re: subject's suicidal ideation
- Dispatch will respond with "clear" and "no wants or PPDS."

Summary

Role-Players

1 female depressed citizen

Fact Situation

Officers get dispatched to a home to do a welfare check

Specifics

Profile of Role-Player: Depressed Woman

You are a 50-something depressed woman. It is the one year anniversary of your partner's death next week. He was killed in a traffic accident a mile from your house by a drunk teenager who ran a stoplight. You have taken leave from work (line supervisor at UPS) for a few weeks because you have not been feeling well. You have trouble sleeping and have lost your appetite but make yourself eat. You no longer go to your church and have stopped socializing with your friends because they don't understand why you are still grieving after a year. Your sister in Texas called Portland 911 because you had talked to her earlier in the day and said you wanted to be dead. You do not have a good relationship with your sister because she never liked your partner because he was (race/religion-you pick). Your brother lives in Canby and took a gun out of your house a month ago for safekeeping. You grew up in Texas and know about firearms. You have a cup from which you take occasional sips. The cup contains alcohol. You started drinking again about two weeks ago. You are seriously thinking about killing yourself. You have heard that you can attach a hose to your exhaust and kill yourself that way. You tried counseling and some meds (Paxil) right after the accident, but it didn't help and you stopped.

Dynamics

When officers knock on the door and ask to check in with you, you open the door and invite them in with a little hesitation. You talk slowly and somewhat mechanically and take a lot of time between answers. You only "smile" perfunctorily but otherwise do not show any signs of joy or contentment.). You look sad and depressed. After a few questions you tell the officer, "Thank you for coming, but I'm going to be fine." Don't

ask them to leave but just insist that you can deal with this yourself. You do not give them a definitive answer re: suicidality. You are very vague with your answers making statements like, "I don't know how to go on" but never admitting you want to kill yourself. However, you don't deny these thoughts either. You tell the officers your sister in Texas is overreacting and "NOW she decides to care about me. She never cared when I was married to Jim." You admit to sipping alcohol when asked. You do not want to go to the hospital or talk to someone today ("Maybe tomorrow.") You don't want police to call family members or friends. No one "understands what it's like." You are vague about means of suicide but admit that you read on the internet about carbon monoxide poisoning with a car and a garage. You have access to both.

Objectives

- Build rapport- avoid rote questioning
- Patience
- Demonstrate suicide risk assessment knowledge
- Follow up on all leads that could give officers information about her history of depression and suicidality
- LISTEN
- Offer community resources (ie. Project Respond)
- Consider putting a POH on subject

Logistics

Location

Camp Withycombe

Props

Cup with liquid

CIT SCENARIO #3: Jubitz truck stop-Liz Lotts

Dispatch

- BOEC dispatches officers to Jubitz Truck Stop
- No wants or PPDS
- No missing persons

Summary

Role Players

1 female (option-you are pregnant)

(If male- he came to Portland to see a Blazer's game and start a fitness gym)

Fact Situation

Officers are dispatched to Jubitz Truck Stop after a trucker called 911 reporting a "weird lady" who arrived by truck at 2 am. It is currently 6 am. The caller has left and is on his way to Idaho.

Specifics

Profile of Role Player

You are a thirty-something year-old who caught a ride with a trucker from Sparks, Nevada to the Jubitz in Portland. You are dressed in clean flannel pajamas. You are very easy to engage and in fact talk incessantly. You have an attitude, for example, suggesting the officer is a "Type A" who doesn't feel comfortable without a plan when the officer asks what your plans are. You only have a credit card. You came to Portland because you want to go to Nordstrom's to buy "Jimmy Choo" shoes for your upcoming wedding in Nevada. You plan to return to Sparks after you buy your shoes. You have a fiancée there but refuse to give his name or the name of any other family members ("they are sleeping!"). You admit to having taken meds in the past (Depakote) but say they bloat you and you don't want to be bloated for your wedding. You haven't slept and have only eaten a muffin in the last 24 hours. You do not think going from Sparks, NV to Portland with a strange trucker is risky behavior ("he was very nice and even had a bed in the back") and would consider returning to Sparks the same way. You decline to go to the hospital. After some time, you admit she was in a "hospital-slash-spa" before coming to Portland but didn't like it there because it didn't have high-speed internet access. After a lot of talking you admit that you had voluntarily checked yourself into Sparks General Hospital because of feeling "overwhelmed." However, you walked out after a few days. You were not on a hold there.

Dynamics

When police arrive you have no trouble rambling on about your wedding, the anxiety you feel about it and the problems you are having with your soon-to-be mother-in-law etc. Police have a hard time interrupting you, but you do stop and listen to them. You feel they are exaggerating the dangerousness of your situation and just want them to give you a ride to Nordstrom's. You don't give them any family information and only reluctantly

admit to being in a hospital/spa. You are not suicidal or homicidal. You have no coherent plan for food, transportation or anything else. You show extremely bad judgment and have no insight into the potential pitfalls of your plan.

Disposition: Police should strongly consider a hold or at least detaining her until they can get more information.

Objectives

- Stay focused on safety assessment questions despite subject's many tangential thoughts
- Consider whether subject will get "better" without intervention
- Run her as a missing person
- Recognize subject is in a manic state and the symptoms associated with mania
- Use appropriate communication techniques (firm but respectful)
- Keep your cool despite her sarcastic attitude towards you
- Assess her for a hold
- Realize after a few minutes that continuing to reason with subject will not produce results. Questions should be asked to determine her mental status, not to reason with her.

Logistics

Props

Flannel pajamas

Wedding magazine or pictures of wedding dresses

M & M's or other candy that could be used as "wedding favors"

CIT SCENARIO #4: Woman in Bank

Dispatch

- BOEC dispatches officer to US Bank on the corner of NW 23rd and Kearney.

Summary

Role Players

1 man or woman, nicely dressed
Bank manager

Fact Situation

Officers get called to the bank by a bank manager who reports that one of their customers is demanding \$30,000 from her bank account. She does not have \$30,000 in the bank and is becoming agitated and will not leave.

Specifics

Role Player

Woman: You believe that you have \$30,000 in your bank account. In fact, there is only \$662 in your account but you don't believe the teller and have been demanding to speak to a manager. However, the manager tells you the same thing and you keep insisting that you want to withdraw money that is rightfully yours.

You tell the officers you are in a hurry to catch a private plane to Barbados where you have been invited to be part of a Texas Hold'Em poker competition. You say you won the competition last year. Your father is a powerful lawyer in LA (worked with Johnny Cochran on the OJ case) and you will call him if the bank doesn't give you your money. You are constantly checking your cell phone and your pager and pacing in the lobby of the bank. You do not take medication ("Why would I take medication? I am not sick.") Your family has wanted to hospitalize you in the past for "doing too much." You are not suicidal/homicidal and have no prior criminal history, warrants or wants.

Bank Manager: You tell police you do not want to trespass your client here but wants her to get help. She has an account at this bank and has been a customer for many years without incident.

Dynamics

When officers show up on the scene, the customer is pacing back and forth in the lobby of the bank. She is nicely dressed and carrying a suitcase. Officers obtain the story from the bank manager and then talk to you. You are convinced about you have \$30,000 in an account and are also convinced your uncle owns the Pearl District and can vouch for you. You bristle when officers suggest you might be "manic" and state that you just "have a lot of energy and gets things done." That is why you are ready for a vacation in Barbados and you are in a hurry to get to your private jet. You have a limo service that is picking

you up from the bank and you do not own a car. You belittle the officers and insult their intelligence. You are arrogant and haughty and treat other people like peons. You initially report that you stay at the Benson, but later you admit that you live on the corner of NW Everett and 19th. When asked what you will do if you don't get your money, you hesitate and sputter and posture and then say you will just go to another branch.

Consider having calling Project Respond to do a welfare check on client that evening.

Objectives

- Recognize subject is in a manic state and the symptoms associated with mania
- Risk assessment questions such as "If you don't get your money, what will you do?"
- Maintain composure despite subject's arrogant attitude
- Observe officer safety while engaging subject
- Recognize that subject is delusional and grandiose
- Do not attempt to talk subject out of her delusions
- Assess for substance abuse
- Assess for physical symptoms/risks of mania (e.g. dehydration, sleep, food)
- Assess for POH
- Focus on problem-solving the crisis and not subject's delusions and tangential thoughts

Logistics**Location****Props**

Briefcase

Cell phone and/or pager or Blackberry

CIT SCENARIO #1: Person with psychotic symptoms ("Raylyn")

Dispatch

- Officer dispatched in response to call from manager to BOEC
- No wants or hits in PPDS

Summary

Role Players

1 male or female ("Ray" or "Raylyn")

1 male or female apartment manager

Fact Situation

Officers respond to dispatch to check the welfare of a man/woman in the lobby of a downtown SRO (single room occupancy). Subject lives at this facility and has paid the rent.

Specifics

Profile of subject standing in the lobby ("Ray or Raylyn")

You are middle-aged and have been standing in the lobby of this downtown SRO for the past 5 hours. You are initially hesitant to engage with police, giving only short, one-word answers. You have been living at this address for the past year and a half. You are standing in the lobby because it is the only place you think is "safe." After some questioning, you tell police that you believe radioactive rays are coming through the walls and vents in your room. You have been experiencing these "rays" on and off for the past 25 years. Your MO is to move every time they become unbearable. You have seen a caseworker at Cascadia in the past but she is on vacation and you heard that Cascadia was sold. You stopped taking your medication about 4 weeks ago. You do not drink or use drugs. You do not have a coherent plan for dealing with the rays, other than not returning to her room. You can decide whether you are hearing voices or are just paranoid. If officers decide to go to your room they will discover that you have put duct tape on the vents and around the windows.

Profile of manager:

You are a "hands-off" type of manager who does not concern yourself with your residents, other than to collect the rent and make sure the rooms don't get trashed. You report to the officers that this is unusual behavior for the subject. You don't know if the subject has family/friends but seems like a "loner."

Dynamics

When police arrive they briefly talk to the manager who gives limited information and wants the police to "take care of it." The subject has not been threatening but has not

been entirely friendly either. The subject makes limited eye contact and gives brief answers. Police need to spend some time on rapport building before the subject will start to talk about his paranoid delusions involving rays. If police question your firm belief in the rays, you become more agitated. Police will try to get subject to a hospital but he doesn't believe hospitals are helpful. After showing concern for his well-being the subject divulges information regarding his previous services with Cascadia and his belief that Cascadia has been sold and he can no longer go to 12th Ave.

Objectives

- Use rapport-building techniques
- Find the balance between asking about the subject's delusions but not buying into the delusions
- Show awareness of officer safety while communicating concern for subject's situation (fear, inability to go back to his room, food etc.)
- Utilize community resources (ie. Project Respond)
- Focus on mitigating subject's current crisis by asking appropriate medical/mental health related questions
- Assess for POH
- Assess extent of delusion (ie. Does it include contaminated food/water?)
- Educate the manager in a professional manner as to the limits of your authority

Logistics

Location

Props

CIT SCENARIO #2: "Sam"

Dispatch

- BOEC dispatches officer to Borders Bookstore
- Officer will run person for wants
- "Clear" with no "wants or PPDS"

Summary

Role-players

1 homeless male

Fact Situation

A concerned citizen called 911 to report a man who looked like he could use some help. Officers are called to "Borders Bookstore" to check on the man who is wearing multiple layers of clothing, looks to be homeless, and is muttering to himself and circling a bicycle non-stop.

Specifics

Profile of role player

You are a homeless man who is experiencing psychotic symptoms. You are walking in circles around a bicycle because it is "your job." A man, "green hair," asked you to guard the bicycle while he went into the bookstore. He said he would give you a dollar if you guarded his bicycle. You are hearing voices and talking back to your voices. It is difficult for you to focus on the officer and his/her questions and there is a delay in your answers. Your thinking is concrete (Q: Can you give me your name? A: Yes). You voices are absurd and bordering on inappropriate. They are not of a command nature and are not suggesting you harm yourself or others. The voices sometimes make you laugh. You will share what they are saying. When asked where you live you say, "Portland." You can confirm that you ate today at the "Blanchet House" but cannot tell the officer the exact date of the month. You are not on medication and do not have a medical provider or counselor. You do say that you sometimes see "Jim" who gives you cigarettes and coffee.

Dynamics

When officers approach the subject he barely looks up and continues to stay in his own world. Officers need to get his attention several times ("Sir, SIR"). Subject readily engages with officers but has a difficult time staying focused on their questions. He is experiencing psychotic symptoms but can also answer questions regarding his ability to meet his basic needs. Officers assess subject for a hold.

Objectives

- Use communication techniques appropriate for someone who is hearing voices (repetition, use of name, wait longer than “normal,” non-threatening)
- Ask risk assessment question to determine the tenure of the voices (command?)
- Ask risk assessment questions – If not X, then what? E.g. “I
- Ask questions to determine subject’s ability to care for self
- Show awareness of officer safety while communicating concern for subject’s situation
- Utilize community resources (ie. Project Respond’s outreach coordinator, Jim)
- Use creative problem-solving (find “green hair” in the bookstore, have owner of the bike paged in the bookstore, call Jim and arrange to have him meet with subject later on in the day)

Logistics

Location

Props

Bicycle

Oversized raincoat

Hat

Crumpled up newspaper for pockets